

12598

CERTIFICATE OF DEATH

12580

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Ranier</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>3218 Chillum Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Christina</u> Last <u>Adams</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 14 1898</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Henry Knott</u>				14. MOTHER'S MAIDEN NAME <u>Georgianus</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hepatitis</u> DUE TO (c) <u>Pyelonephritis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 months</u> <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis of liver</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 6, 1956</u> to <u>Dec 21, 1956</u> , that I last saw the deceased alive on <u>Dec 21, 1956</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eino Magi</u>				ADDRESS (Street, city or town, state) <u>8401 University Lane, Silver Spring, Md.</u>			
DATE SIGNED <u>12/21/56</u>							
PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec 24, 1956</u>		<u>Mt. Olivet</u>		<u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm. Lees Sons & Co. Inc.</u>				ADDRESS <u>3004 85th St. N.E. DC</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 27 1956</u>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12581

12633

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>26 E Montgomery ave.</u>	

3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Arnold</u>		4. DATE OF DEATH Month <u>December</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OF RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 8, 1956</u>
9. AGE (In years last birthday) yrs. <u>5</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>31</u> Hours <u>31</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

13. FATHER'S NAME <u>Walter Floyd Arnold</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Clement</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>	17. INFORMANT <u>Mother</u> Address <u>Same</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs. 31 min.</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>Dec 8, 1956</u> , to <u>Dec 9, 1956</u> , that I last saw the deceased alive on <u>Dec 8, 1956</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>615 W. Montgomery Ave. Rockville, Md.</u>	
ACTUAL SIGNATURE <u>W.G. Hall</u>		DATE SIGNED <u>12-10-56</u>	
PHYSICIAN'S NAME (Type) <u>W.G. Hall</u>		615 W. Montg. Ave. Rockville, Md. 12-10-56	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-11-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md</u>	24a. REC'D BY REGISTRAR <u>Beenie M. Thompson</u>
		DATE <u>12-11-56</u>	24b. REGISTRAR'S SIGNATURE

2074213XVI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		JAN 15 1911		NEW YORK	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
123 MAIN ST. BOSTON		LABORER		HEART DISEASE		NATURAL		DEC 10 1956		HOSPITAL	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
DEC 10 1956		HOSPITAL		DEC 10 1956		HOSPITAL		DEC 10 1956		HOSPITAL	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
DEC 10 1956		HOSPITAL		DEC 10 1956		HOSPITAL		DEC 10 1956		HOSPITAL	

BUREAU V. 2

DEC 13 1956

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12634

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4513 Saul Rd.</u>				d. STREET ADDRESS <u>4513 Saul Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Martha</u> Last <u>ASMAN</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>5</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-10-56</u>		9. AGE (In years last birthday) yrs. <u>62</u>	IF UNDER 1 YEAR Months <u>62</u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert J. Asman</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Kane</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Robt. J. Asman, Jr. Father</u>		Address <u>4513 Saul Rd. Kensington, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUFFOCATION DUE TO ASPIRATED VOMITUS</u> <u>470x</u> DUE TO <u>RHINOPHARYNGITIS & LARYNGITIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>14 Hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-4-56</u> , 19 <u>56</u> , to <u>12-5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-4-56</u> , 19 <u></u> , and that death occurred at <u>12:41</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William S. Anderson</u>		M.D. <u>1901 Wyoming Ave. NW</u>		ADDRESS (Street, city or town, state) <u>Wash DC</u>		DATE SIGNED <u>12-5-56</u>	
PHYSICIAN'S NAME (Type) <u>William S. Anderson</u>		1901 Wyoming Ave. N.W., Washington, DC					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-6-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Md</u>		24a. REC'D BY REGISTRAR DATE <u>12-6-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

DEC 7 1956

BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12635 CERTIFICATE OF DEATH

12583

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>9318 WORTH AVENUE</u>			
3. NAME OF DECEASED (Type or print) <u>Phillip Johnston Austensen</u>				4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-2-02</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reporter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>LEVI AUSTENSEN</u>				14. MOTHER'S MAIDEN NAME <u>MARY E. JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-03-2978</u>		17. INFORMANT <u>Phillip (son)</u> Address <u>9318 WORTH AVE SS, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary thrombosis & embolism</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction + CHD</u> DUE TO (c) <u>Coronary arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u> <u>3 yrs</u> <u>Indef.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1953</u> , to <u>12/18/56</u> , that I last saw the deceased alive on <u>12/18/56</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stephen N. Jones</u> M.D.				ADDRESS (Street, city or town, state) <u>Rockville Md.</u>		DATE SIGNED <u>12/18/56</u>	
PHYSICIAN'S NAME (Type) <u>STEPHEN N. JONES</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/21/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey Jr.</u>				23a. REC'D BY REGISTRAR <u>12-22-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Humphrey</u>	

CERTIFICATE OF DEATH

[Faint, mostly illegible text from the reverse side of the document is visible through the paper.]

RECEIVED
DEC 31 1956
BUREAU Y. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12636

New file 4600 5/15/56

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster Hills</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster Hills</u>			
c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u>				d. STREET ADDRESS <u>5237 Mass Ave (Wash 16)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5237 Mass Ave - (Wash 16)</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Freeland Bachman</u>				4. DATE OF DEATH Month Day Year <u>Dec 8 1956</u>			
5. SEX <u>male</u>		6. COLOR OF SKIN <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-21-'03</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Theatre manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>motoring</u>			
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>			
13. FATHER'S NAME <u>Jacob Bachman</u>				14. MOTHER'S MAIDEN NAME <u>Mary Tangier</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>577-05-3030</u>			
17. INFORMANT <u>Philonema Bachman (wife)</u>				Address <u>Wash 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>12-8-56</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u></u>				22b. DATE THEREOF <u>12/11/56</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.</u>				ADDRESS <u>Wash. D.C.</u>			
24a. REC'D BY REGISTRAR <u>12-11-56</u>				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

DEC 13 1956

BUREAU V. S.

Neven

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12599

CERTIFICATE OF DEATH

12585

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>2 hrs</u>				56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp.</u>				d. STREET ADDRESS <u>610 Gist Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Rhoda</u> First <u>Elizabeth</u> Middle <u>Baxter</u> Last				4. DATE OF DEATH <u>12</u> Month <u>20</u> Day <u>1956</u> Year			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-3-1879</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Vanderbilt</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hosp Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral emboli</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>48</u> , to <u>Dec 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>56</u> , and that death occurred at <u>12:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. B. Wardrop ml</u>				ADDRESS (Street, city or town, state) <u>837 Bonaparte St. Delmar, DE</u>			
PHYSICIAN'S NAME (Type) <u>W. B. WARDROP</u>				DATE SIGNED <u>12/20/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>8434 4th Ave. S.S.M.D.</u>		24a. REC'D BY REGISTRAR <u>J. Wilson</u>	
				DATE <u>12/24/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH	
9. MARITAL STATUS		10. COLOR		11. EDUCATION		12. RELIGION		13. PREVIOUS ILLNESS		14. PREVIOUS SURGERY		15. PREVIOUS TRAUMA		16. PREVIOUS DRUGS	
17. DATE OF DEATH		18. TIME OF DEATH		19. PLACE OF DEATH		20. NAME OF PHYSICIAN		21. SIGNATURE OF PHYSICIAN		22. SIGNATURE OF REGISTRAR		23. SIGNATURE OF WITNESS		24. SIGNATURE OF DECEASED	
25. NAME OF FUNERAL HOME		26. ADDRESS OF FUNERAL HOME		27. CITY OF FUNERAL HOME		28. STATE OF FUNERAL HOME		29. ZIP CODE OF FUNERAL HOME		30. PHONE NUMBER OF FUNERAL HOME		31. NAME OF FUNERAL HOME		32. ADDRESS OF FUNERAL HOME	

BUREAU V. S.

DEC 26 1956

RECEIVED

CERTIFICATE OF DEATH

12586

Reg. Dist. No. 216

12637

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4605 W. Virginia Ave.				d. STREET ADDRESS 4605 W. Virginia Ave			
3. NAME OF DECEASED (Type or print) First Middle Last OPAL DALEY BECK				4. DATE OF DEATH Month Day Year December 14, 1956			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 21, 1900	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 10 Days 23		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Hugh Daley				14. MOTHER'S MAIDEN NAME Anna Shields			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT John M. Beck-Item # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 356.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Respiratory Failure (c) Progressive Bulbar Palsy				INTERVAL BETWEEN ONSET AND DEATH 2 hours 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from December 10, 1956 to December 14, 1956 , that I lost s/he the deceased alive on December 10, 1956 , and that death occurred at 6:00 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank Y. Jagers Jr. M.D.				ADDRESS (Street, city or town, state) 5707 Wisconsin Ave			
PHYSICIAN'S NAME (Type) Frank Y. Jagers, Jr.				DATE SIGNED 12/15/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/17/56		22c. NAME OF CEMETERY OR CREMATORY Parklawn	
22d. LOCATION (City, town, or county) (State) Rockville, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR 12-81 06		24b. REGISTRAR'S SIGNATURE Bernie M. Thompson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

DEC 21 1956

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Robert A. Murphy-Bell, Jr.

12625 CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>1633-S. Carverton Ave.</u> b. COUNTY <u>S.E.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West. B.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor</u>				d. STREET ADDRESS <u>12201-Rockville Pike</u>			
3. NAME OF DECEASED (Type or print) First <u>Myrtle</u> L. Middle <u>B.</u> Last <u>Beckwith</u>				4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 16, 1880</u> 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Leander H. Zook</u>				14. MOTHER'S MAIDEN NAME <u>Alice M. Merick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-4428</u>		17. INFORMANT <u>Daniel J. Wilson</u> Address <u>2605-Southernline</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular renal disease</u> <u>4428</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arthritis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10-15</u> , 19 <u>46</u> , to <u>12-28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-28</u> , 19 <u>56</u> , and that death occurred at <u>3:05 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl W. Graeff</u>				ADDRESS (Street, city or town, state) <u>2716 Kirkwood Place, M.D.</u>			
PHYSICIAN'S NAME (Type) <u>EARL W. GRAEFF, M.D.</u>				DATE SIGNED <u>W. H. Hayton, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 2, 1957</u>		<u>Arlington Path</u>		<u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Lee's Sons Co.</u>				ADDRESS <u>308-4th St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>12/31/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Harrell Knapton</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>Charles H. Frost</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>68</i></p>		<p>4. DATE OF BIRTH <i>Oct 11, 1888</i></p>	
<p>5. PLACE OF BIRTH <i>Chesapeake, Md.</i></p>		<p>6. OCCUPATION <i>Retired</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF DEATH <i>Dec 1, 1956</i></p>	
<p>9. PLACE OF DEATH <i>Home</i></p>		<p>10. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>11. MEDICAL HISTORY <i>None</i></p>		<p>12. SIGNATURE OF PHYSICIAN <i>John H. Frost</i></p>	
<p>13. SIGNATURE OF REGISTRAR <i>John H. Frost</i></p>		<p>14. SIGNATURE OF WITNESSES <i>John H. Frost</i></p>	

RECEIVED
DEC 1 1956
BUREAU OF

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. MARITAL STATUS
8. DATE OF DEATH
9. PLACE OF DEATH
10. CAUSE OF DEATH
11. MEDICAL HISTORY
12. SIGNATURE OF PHYSICIAN
13. SIGNATURE OF REGISTRAR
14. SIGNATURE OF WITNESSES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12588

Reg. Dist. No. 214

12638

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2209 Forest Glen Rd.</u>				d. STREET ADDRESS <u>3800 New Hampshire Ave N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Bessie Carlotta Behrens</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>25</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 4, 1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Carl Schnebel</u>			
14. MOTHER'S MAIDEN NAME <u>Emma Piepenbring</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>Carlton R. Behrens, 2209 Forest Glen Road, SS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> </div> <div style="width: 35%;"> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Bronhart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Bronhart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>12-25-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 28, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>12/27/56</u>	
24b. REGISTRAR'S SIGNATURE <u>James Potter</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 14
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 31 1956
STANDARD Y

12639

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7731 Bradley Boulevard		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clara Middle Moran Last Bernheimer		4. DATE OF DEATH Month Dec Day 25 Year 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 26, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6 Days 29 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music teacher		10b. KIND OF BUSINESS OR INDUSTRY self-retired	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Edward Moran		14. MOTHER'S MAIDEN NAME Susanna Lovelace	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 77-09-0416B	
17. INFORMANT Address Mrs. Joseph Ehrman-Same Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, generalizzed DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of bladder DUE TO (c) Carcinoma rt. breast			INTERVAL BETWEEN ONSET AND DEATH 4 mos. 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1952 to Dec 25, 1956 , that I last saw the deceased alive on Dec 25, 1956 , and that death occurred at 11:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Armand B. Gordon M.D. 2828 Conn. Ave. N.W., Wash. D.C.		DATE SIGNED 12/25/56	
PHYSICIAN'S NAME (Type) Armand B. Gordon, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/28/1956	22c. NAME OF CEMETERY OR CREMATORY Rock Creek	22d. LOCATION (City, town, or county) (State) Washington D. C.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.		24a. REC'D BY REGISTRAR 12-29-56	24b. REGISTRAR'S SIGNATURE Bessie M. Humpherson

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SECTION 8

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CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>30 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS <u>244 West Notley Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Americus Edgar Biggs</u>				4. DATE OF DEATH Month Day Year <u>December 24 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/1/79</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Justice of Peace</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Americus Biggs</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Whalen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Archie A. Biggs</u> <u>Hospital Record (Son) Same as No. 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> <u>163x</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>Dec</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 24</u> , 19 <u>56</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>A. D. Bonifant</u> M.D. <u>Silver Spring Md 12/24/56</u> PHYSICIAN'S NAME (Type) <u>A. D. Bonifant, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEELSVILLE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEELSVILLE, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>12-26-56</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur B. Lawry</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12641

CERTIFICATE OF DEATH

Reg. Dist. No. 12591

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Sylvia Middle Regina Last BLACKWELL			4. DATE OF DEATH Month December Day 18 Year 1956				
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 11, 1956		9. AGE (In years last birthday) yrs. 4 Months 7 Days 7 Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia			
13. FATHER'S NAME Charles (n) Blackwell				14. MOTHER'S MAIDEN NAME Sarah Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Mother) Mrs. Sarah E. Thompson (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub Endocardial Fibrous elastosis 754.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 mds	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 11 August , 19 56 , to 18 December , 19 56 , that I last saw the deceased alive on 18 Dec. , 19 56 , and that death occurred at 3:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Henry B. Karpinski M.D. U.S. Naval Hospital, Bethesda, Md. 12-19-56 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Henry B. Karpinski, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-21-56	22c. NAME OF CEMETERY OR CREMATORY Private Church Cemetery		22d. LOCATION (City, town, or county) (State) Lawrenceville, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE W.H. Bacon Funeral Home, 1722 7th St. N.W.			24a. REC'D BY REGISTRAR DATE 12-19-56		24b. REGISTRAR'S SIGNATURE May E. Parrelly		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12600

CERTIFICATE OF DEATH

12592

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Longley Park, Maryland</u> b. COUNTY <u>P.A.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Maryland</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Longley Park, Maryland</u>		
c. LENGTH OF STAY IN 1b <u>1 hour - 10 min</u>			16-2		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>			d. STREET ADDRESS <u>8317 14th Ave.</u>		
3. NAME OF DECEASED (Type or print) <u>Philip</u> First <u>N.M.H. Bluestein</u> Middle <u>Bluestein</u> Last			4. DATE OF DEATH <u>December 18</u> Month <u>18</u> Day <u>1956</u> Year		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-27-92</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>merchant</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Bluestein</u> <u>Not available</u>			
14. MOTHER'S MAIDEN NAME <u>Not available</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>patient's Hospital chart.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> <u>443X</u> DUE TO (b) <u>Art. Hypertensive Heart Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>3 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>55</u> , to <u>Dec 17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 17</u> , 19 <u>56</u> , and that death occurred at <u>1:40 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>915-19th St. NW</u> DATE SIGNED <u>Wash. D.C.</u>			
ACTUAL SIGNATURE <u>Isidore Shulman</u> M.D.		PHYSICIAN'S NAME (Type) <u>Isidore Shulman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-20-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New York</u>	
22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>3501-14th St</u>			
24a. REC'D BY REGISTRAR DATE <u>12-22-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12593

Reg. Dist. No. 217

12642

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 24 hrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montg. Co. Gen. Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenwood	
4. DATE OF DEATH Month Dec. Day 8 Year 1956		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Donnie Lee Bowling		5. SEX male	
6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11/1/56		9. AGE (In years last birthday) 1 yrs. 7 months 9 days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME T.J. Bowling		14. MOTHER'S MAIDEN NAME Irene Seal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hosp. Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 816X DUE TO Fracture of Skull Conditions, if any, which gave rise to immediate cause (b) Fracture of Skull (c) Fracture of Skull DUE TO Fracture of Skull cause lost.			
INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was passenger in auto on head on collision	
20c. TIME OF INJURY Month, Day, Year 11 Hour 1:00 p. m. 12/7 19 56		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Md R- 32		20f. (City or town) Nr W. Fredship (County) Howard (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/9/56	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 11, 56	
22c. NAME OF CEMETERY OR CREMATORY Siobon		22d. LOCATION (City, town, or county) Howard (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		24a. REC'D BY REGISTRAR 12-12-56	
ADDRESS Laytonsville		24b. REGISTRAR'S SIGNATURE Colaud B. Lawler	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
J. Edgar Hoover		Male		58 yrs		White		Dec 19 1956		Washington, D.C.	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Previous Illnesses	
Heart Disease		Natural		President		College		Married		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Deceased	
J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover	

BUREAU V. S.

DEC 19 1956

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Chief of Bureau
 J. Edgar Hoover

12643

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Dist of Columbia</u> COUNTY <u>Washington D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>69 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>		47X 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resmor Sanitarium & Hospital</u>				d. STREET ADDRESS <u>2821 Rittenhouse St. NW.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jeremiah Christopher Broderick</u>				4. DATE OF DEATH Month Day Year <u>December 28 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 8, 1880</u>	9. AGE (In years last birthday) yrs. <u>76</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Broderick</u>				14. MOTHER'S MAIDEN NAME <u>Catherine O'Connell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Francis M. McCormick 2821 Rittenhouse St. Wash.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>WIDESPREAD METASTASIS</u> DUE TO (c) <u>CARCINOMA OF PROSTATE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 mos.</u> <u>2 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>OCT 1956</u> , to <u>28 DEC. 1956</u> , that I last saw the deceased alive on <u>26 DEC. 1956</u> , and that death occurred at <u>5:35 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles J. Savarese Jr.</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>4861 BATTERY LANE 12/28/56</u>			
PHYSICIAN'S NAME (Type) <u>CHARLES J. SAVARESE JR.</u>				<u>BETHESDA, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12-31-56</u>		<u>MT. OLIVET</u>		<u>WASH D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Timothy Hanlon - 3831-GA. Ave N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>12/31/56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 31 1956

RECEIVED
DEC 31 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12044

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12596
2/6

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN lb D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Surburban Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS 4025 Plyers Mill Road			
3. NAME OF DECEASED (Type or print) First George Middle H. Last Brown				4. DATE OF DEATH Month Dec. Day 30, Year 1956			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1895		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caddy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Brown, Sr.				14. MOTHER'S MAIDEN NAME Jennie Warren			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Ethel Bradley (Sister) Address 920 Fla. Ave. N.W. D. C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify)				22b. DATE THEREOF 1-3-57		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
				22d. LOCATION (City, town, or county) (State) Arlington, VA.			
23. FUNERAL DIRECTOR'S SIGNATURE JOSEPH SYERS, CORNISH				24a. REC'D BY REGISTRAR 1/4/57		24b. REGISTRAR'S SIGNATURE Jessie Thompson	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WEST AND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 4 1957

RECEIVED

1-3-57
JAN 4 1957
JAN 4 1957

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12601
CERTIFICATE OF DEATH

12597

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>21 Hrs.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>1402 Elson Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Katherine Marie Brown</u>				4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1956</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-9-06</u>		9. AGE (In years last birthday) <u>50</u> yrs. <table border="1" style="float:right; width:100px;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.														
Months	Days														
	Hours														
	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Hugh P. Hammer</u>				14. MOTHER'S MAIDEN NAME <u>Marie True</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Hospital Records</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> <u>331x</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>6 mos -</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____									
21. I certify that I attended the deceased from <u>Dec 4</u> , 19 <u>56</u> , to <u>Dec 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 19</u> , 19 <u>56</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above.															
ACTUAL SIGNATURE <u>Ernest H. Sarao M.D.</u>				ADDRESS (Street, city or town, state) <u>7006 NEW HAMPSHIRE AVE</u>		DATE SIGNED <u>12/20/56</u>									
PHYSICIAN'S NAME (Type) <u>ERNEST A. SARAO M.D.</u>				<u>TAKOMA PARK 12 MD.</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 24, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Wheaton</u> <u>MD.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur M. ...</u>				ADDRESS <u>254 Campbell St. N.W.</u>		24a. REC'D BY REGISTRAR <u>DATE 11/1/56</u>									
				24b. REGISTRAR'S SIGNATURE <u>J. Nelson Dodd</u>											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

DEC 26 1956

BUREAU V. 21

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 15
CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. PLACE OF DEATH: [illegible]
9. DATE OF DEATH: [illegible]
10. SIGNATURE OF PHYSICIAN: [illegible]
11. SIGNATURE OF REGISTRAR: [illegible]
12. SIGNATURE OF WITNESS: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12602 CERTIFICATE OF DEATH

Reg. Dist. No.

12598
214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 8202 ROANOKE AVE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ALFRED Last BURNETT				4. DATE OF DEATH Month December Day 13 Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 26, 1864		9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CABINET MAKER				10b. KIND OF BUSINESS OR INDUSTRY NAVY DEPT. RETIRED		11. BIRTHPLACE (State or foreign country) BALT. MD	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		17. INFORMANT OLIVE M BURNETT		Address 8202 Roanoke Ave Takoma Park Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL ARTERIOSCLEROSIS						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from July 24, 1953 to December 12, 1956 , that I last saw the deceased alive on Dec. 12, 1956 , and that death occurred at 8:55 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Israel Kessler				M.D. 5801-16 45th NW, Wash, DC DATE SIGNED 12-13-56			
PHYSICIAN'S NAME (Type) ISRAEL KESSLER, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-15-56		22c. NAME OF CEMETERY OR CREMATORY LOUPON PARK		22d. LOCATION (City, town, or county) (State) BALTIMORE MD	
23. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home				ADDRESS 4812 14th Ave NW WASH DC		24a. REC'D BY REGISTRAR DATE 12/17/56	
				24b. REGISTRAR'S SIGNATURE James Potter			

CERTIFICATE OF DEATH

NAME OF DECEASED MRS. J. M. BARNETT		AGE 52		SEX F		RACE W	
DATE OF DEATH DEC 12, 1956		PLACE OF DEATH HOME		CITY BALTIMORE		STATE MD	
OCCUPATION HOUSEWIFE		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		MEDICAL ATTENDANCE YES	
DATE OF BIRTH OCT 10, 1904		PLACE OF BIRTH BALTIMORE		CITY BALTIMORE		STATE MD	
FATHER'S NAME J. M. BARNETT		MOTHER'S NAME M. J. BARNETT		FATHER'S OCCUPATION CLOCK MAKER		MOTHER'S OCCUPATION HOUSEWIFE	
FATHER'S ADDRESS 1234 E. BALTIMORE		MOTHER'S ADDRESS 1234 E. BALTIMORE		FATHER'S PHONE 1234		MOTHER'S PHONE 1234	
FATHER'S SIGNATURE J. M. BARNETT		MOTHER'S SIGNATURE M. J. BARNETT		DECEASED'S SIGNATURE MRS. J. M. BARNETT		WITNESSES' SIGNATURES	
FATHER'S ADDRESS 1234 E. BALTIMORE		MOTHER'S ADDRESS 1234 E. BALTIMORE		DECEASED'S ADDRESS 1234 E. BALTIMORE		WITNESSES' ADDRESSES	

BUREAU V. S.

DEC 20 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12599

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Leslie Byram		4. DATE OF DEATH Month December Day 30 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1886
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Unascertainable	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James N. Byram		14. MOTHER'S MAIDEN NAME Virginia Harris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 579-28-5757	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis rt. coronary artery 420.1 DUE TO myocardial infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic myelogenous leukemia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour - o. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 17, 1956 , to December 30, 1956 , that I last saw the deceased alive on December 30, 1956 , and that death occurred at 4:20 a.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Weissman		M.D. The Clinical Center 12/30/56	
PHYSICIAN'S NAME (Type) Sherman M. Weissman, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		1/2/57	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Cedar Hill Cemetery		Scitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee		ADDRESS Washington D.C.	
24a. REC'D BY REGISTRAR 1 JAN 3 1957		24b. REGISTRAR'S SIGNATURE Bess Thompson	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12645

CERTIFICATE OF DEATH

12600

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE D.C. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN 1b 3 MO			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Rest Home				d. STREET ADDRESS 1720 34th Street, N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JOHN T CAMPBELL				4. DATE OF DEATH Month DEC Day 24 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/4/1881	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 24 Days 24 Hours 19 Min.		IF UNDER 24 HRS. Months 24 Days 24 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interstate Commerce Commission				10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ARTHUR CAMPBELL				14. MOTHER'S MAIDEN NAME SARAH SCHWARTZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Arthur J. Campbell-5904 Cobalt Road Washington 16, D.C.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary sclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Advanced Generalized Arteriosclerosis DUE TO (c) 107 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov 27, 1956 , to Dec 24, 1956 , that I last saw the deceased alive on Dec 27, 1956 , and that death occurred at 6:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. Stephen Hulburt				ADDRESS (Street, city or town, state) 3000 Dent Pl. N.W. Wash, D.C.			
PHYSICIAN'S NAME (Type) R. Stephen Hulburt, M.D.				DATE SIGNED Dec 24, 56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/27/56			
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery				22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.				ADDRESS 2901 14th St. N.W. Washington, D.C.			
24a. REC'D BY REGISTRAR 12-27-56				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

CERTIFICATE OF DEATH

NAME OF DECEASED WILLIAM H. HUBBARD		DATE OF DEATH DEC 21 1956	
AGE 64		SEX M	
RACE W		MARRIAGE M	
OCCUPATION RETIRED		CAUSE OF DEATH CORONARY THROMBOSIS	
PLACE OF DEATH HOME		DATE OF BIRTH DEC 21 1892	
PLACE OF BIRTH BALTIMORE, MD		EDUCATION HIGH SCHOOL	
MANNER OF DEATH NATURAL		SIGNATURE OF DECEASED (None)	
SIGNATURE OF WITNESSES (None)		SIGNATURE OF PHYSICIAN (None)	
SIGNATURE OF CLERK (None)		SIGNATURE OF REGISTRAR (None)	

RECEIVED
DEC 31 1956
BUREAU OF VITALS

DEC 21 1956
WILLIAM HUBBARD
3000 DOWD PL NW WASH DC
3000 DOWD PL NW WASH DC

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12601

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

214

12647

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 3 MONTHS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2709 BLUE RIDGE AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE LAST BREND A JANE CARTER		4. DATE OF DEATH Month Day Year DEC. 17 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 15, 1956
9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR Months 3 Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ERNEST EUGENE CARTER		14. MOTHER'S MAIDEN NAME MURIEL IMOGENE BOOTH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Ernest E. Carter, 2709 Blue Ridge Ave.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to upper respiratory infection found dead DUE TO (b) in bed DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. BROSCART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Dec. 17, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/19/56	
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE 12/20/56		24b. REGISTRAR'S SIGNATURE Frances Potter	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for patient information, medical history, and examiner's findings.

BUREAU V. 2

DEC 26 - 1956

RECEIVED

12603

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>P. H.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	c. LENGTH OF STAY IN 1b <u>3 hrs - 10 min</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>16 15.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>		d. STREET ADDRESS <u>7906 - 15th Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>YOLANDA</u> Last <u>CHEN</u>		4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Yellow</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 - 17 - 52</u>
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Takoma Park, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Homer Mingen Chen</u>		14. MOTHER'S MAIDEN NAME <u>America Sanchez</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal atelectasis</u> <u>759.3</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital abnormality; possible Mongolism</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 17</u> , 19 <u>56</u> , to <u>Dec 18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 18</u> , 19 <u>56</u> , and that death occurred at <u>12:44 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert J. Friedel</u> M.D. <u>6826 Regg Rd Hyattsville, Md</u>		DATE SIGNED <u>12/18/56</u>	
PHYSICIAN'S NAME (Type) <u>HERBERT J. FRIEDEL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 19, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Elvies Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walker</u> ADDRESS <u>254 Carroll St. N.W. Washington D.C.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>12/20/56</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2075242 XVV

12648

CERTIFICATE OF DEATH

12603

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 57 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 514 Rosemary Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Douglas Middle Sigmund Last Chmura				4. DATE OF DEATH Month December Day 11th Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 28, 1948	
9. AGE (In years lost birthday) 8 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Sigmund Chmura				14. MOTHER'S MAIDEN NAME Nettie F. Guzik			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Acute Lymphocytic leukemia							
INTERVAL BETWEEN ONSET AND DEATH 2 mo 9 mo							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from October 15, 19 56 , to December 11, 19 56 , that I last saw the deceased alive on December 11, 19 56 , and that death occurred at 9:56 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12/11/56 DATE SIGNED							
ACTUAL SIGNATURE James R. Stabenau M.D.				The Clinical Center			
PHYSICIAN'S NAME (Type) James R. Stabenau, M. D.				The National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-12-56		22c. NAME OF CEMETERY OR CREMATORY NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Murphy				ADDRESS 3524 Columbia Rd. Arlington, Va.		24a. REC'D BY REGISTRAR DATE 12-12-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Hornfear			

RECEIVED

12649

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

NAME OF DECEASED JERRY GIBBS		DATE OF BIRTH 1925		SEX Male		RACE White		MARRIAGE Married		EDUCATION High School		OCCUPATION None		RESIDENCE 1234 Main Street, Baltimore, MD	
DATE OF DEATH January 8, 1957		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial Infarction		UNDERLYING CAUSE Coronary Artery Disease		INTERESTING FACTS None		SIGNATURE OF PHYSICIAN J. H. Smith, M.D.	
DATE OF DEATH January 8, 1957		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial Infarction		UNDERLYING CAUSE Coronary Artery Disease		INTERESTING FACTS None		SIGNATURE OF PHYSICIAN J. H. Smith, M.D.	

BUREAU V. 3

JAN 8 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12650

CERTIFICATE OF DEATH

12605

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE West Virginia b. COUNTY Mercer			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 216 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bluefield	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS 1625 Augusta Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Alice Collins				4. DATE OF DEATH Month Day Year December 27th, 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 23, 1944	
9. AGE (In years lost birthday) yrs. 12		IF UNDER 1 YEAR Months Days Hours Min. 7 5		IF UNDER 24 HRS. 19 24			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School girl				10b. KIND OF BUSINESS OR INDUSTRY - -		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Harold E. Collins				14. MOTHER'S MAIDEN NAME Ruth Oliver			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.0 Destructive intestinal hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute lymphocytic leukemia DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 days 9 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary edema						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bluefield				20g. (County) Mercer		20h. (State) West Virginia	
21. I certify that I attended the deceased from May 25, 19 56 to Dec. 27, 19 56 , that I last saw the deceased alive on Dec. 27, 19 56 , and that death occurred at 10:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/28/56 ACTUAL SIGNATURE James R. Stabenau M.D. The National Institutes of Health PHYSICIAN'S NAME (Type) James R. Stabenau, M. D. Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-56		22c. NAME OF CEMETERY OR CREMATORY Monte Vista		22d. LOCATION (City, town, or county) (State) Mercer Co. W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-29-56	
				24b. REGISTRAR'S SIGNATURE Benjamin Thompson			

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
HARRISON		Male		25		1912	
Place of Birth		Race		Color		Religion	
Maryland		White		White		Roman Catholic	
Usual Residence		Address		City		State	
1234 Avenue Street		Avenue		Baltimore		Maryland	
Date of Death		Time of Death		Place of Death		Cause of Death	
Jan 2, 1937		10:30 AM		Home		Heart Disease	
Occupation		Education		Marital Status		Previous Illnesses	
None		None		Single		None	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Report		Time of Report		Place of Report		Cause of Report	
Jan 2, 1937		10:30 AM		Home		Heart Disease	

BUREAU V. S.

JAN 2 1937

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

213

12626

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>209 Adclare Rd.</u>				d. STREET ADDRESS <u>209 Adclare Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Laura Marie Cooperman</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>31</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-12-56</u>	
9. AGE (In years last birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months <u>19</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>19</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Richard M Cooperman</u>				14. MOTHER'S MAIDEN NAME <u>Mary L. Harrison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Father - Same as #2</u>				Address <u>Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenitive heart failure</u> 754.4 DUE TO <u>Multiple Congenital Enormities of heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thin lip and cleft palate</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR <u>JAN 1 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Laurell Kragtop</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JAN 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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12651

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

12607

Reg. Dist. No. 2/17

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Roanoke	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oney		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roanoke	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montg. Co. Gen. Hospital		d. STREET ADDRESS 1061 Hunt Ave. N.W.	
3. NAME OF DECEASED (Type or print) First Clara Middle B. Last Criner		4. DATE OF DEATH Month Dec. Day 31 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 20, 1894
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Bluefield, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles B. Suter		14. MOTHER'S MAIDEN NAME Annie F. Akers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs L. E. Jones, Mt. Airy, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Cancer of Liver 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Primary Cancer of Rectum DUE TO (c) Polypsis of Rectum & Colon		INTERVAL BETWEEN ONSET AND DEATH 3 months 6-12 mos. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 19, 1956 to Dec 31, 1956 , that I last saw the deceased alive on Dec 31, 1956 , and that death occurred at 4:58PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gilcin F. Meadors M.D.		ADDRESS (Street, city or town, state) Bover Clinic DATE SIGNED 1/1/57	
PHYSICIAN'S NAME (Type) Gilcin F. Meadors, M.D.		Damascus, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 3, 1957	22c. NAME OF CEMETERY OR CREMATORY Evergreen	22d. LOCATION (City, town, or county) (State) Roanoke, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Molsworth		ADDRESS Damascus, Md.	
24a. REC'D BY REGISTRAR DATE 1-2-57		24b. REGISTRAR'S SIGNATURE Antwone B. Lowen	

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CERTIFICATE OF DEATH

Reg. Dist. No. 216

12652

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X.3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1621 Newton St. N.E.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie Jameson Deeges</u>				4. DATE OF DEATH Month Day Year <u>12-21-1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-8-15</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Evans</u>				14. MOTHER'S MAIDEN NAME <u>Mary Humphrey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>5423-5</u>		17. INFORMANT Address <u>Washington, D.C.</u> <u>Martina (daughter) 5423-5th St NW</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerotic heart disease</u> DUE TO (c) <u>Generalized arterio-sclerosis.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 2 months</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 15</u> , 19 <u>56</u> , to <u>Dec 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>56</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Walter K. Angevine</u> M.D.				ADDRESS (Street, city or town, state) <u>6300-13th St. NW, Wash. D.C.</u>			
DATE SIGNED <u>12-22-56</u>				24b. REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>			
PHYSICIAN'S NAME (Type) <u>WALTER K. ANGEVINE</u>				24c. REC'D BY REGISTRAR			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>12/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Ft. Myer, Va.</u>	
22d. LOCATION (City, town, or county) (State)				24a. REC'D BY REGISTRAR			
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. 2901 11th St. N.W. Washington, D.C.</u>				24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

I hereby certify that the above is a true and correct statement of the facts as furnished to me by the attending physician or other competent authority.		I hereby certify that the above is a true and correct statement of the facts as furnished to me by the attending physician or other competent authority.	
Name of Deceased: <u>John Doe</u>		Name of Deceased: <u>John Doe</u>	
Date of Death: <u>1956</u>		Date of Death: <u>1956</u>	
Place of Death: <u>Home</u>		Place of Death: <u>Home</u>	
Cause of Death: <u>Heart Disease</u>		Cause of Death: <u>Heart Disease</u>	
Manner of Death: <u>Natural</u>		Manner of Death: <u>Natural</u>	
Age: <u>65</u>		Age: <u>65</u>	
Sex: <u>Male</u>		Sex: <u>Male</u>	
Race: <u>White</u>		Race: <u>White</u>	
Birth Date: <u>1911</u>		Birth Date: <u>1911</u>	
Birth Place: <u>MD</u>		Birth Place: <u>MD</u>	
Usual Residence: <u>123 Main St</u>		Usual Residence: <u>123 Main St</u>	
Date of Report: <u>1956</u>		Date of Report: <u>1956</u>	
Signature of Physician: <u>[Signature]</u>		Signature of Physician: <u>[Signature]</u>	
Signature of Registrar: <u>[Signature]</u>		Signature of Registrar: <u>[Signature]</u>	

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 1956

This is to certify that the above is a true and correct statement of the facts as furnished to me by the attending physician or other competent authority.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12604 CERTIFICATE OF DEATH

Reg. Dist. No. 12610 223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN 1b <u>6 days</u>				d. STREET ADDRESS <u>7220 14th St. N.W.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>INA</u> Middle <u>DEE</u> Last <u>EDDINGFIELD</u>				4. DATE OF DEATH Month <u>12</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14, 1880</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>26</u> Hours <u>19</u> Min. <u>56</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Social worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Indiana</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William T. Eddingfield</u>				14. MOTHER'S MAIDEN NAME <u>Bien Trauers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Hospital records.</u>			
17. INFORMANT <u>Hospital records.</u>				Address <u>Hospital records.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>493X</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>One week</u> DUE TO (c) <u>Terminal</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension and Vase. Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 20, 1956</u> to <u>Dec 26, 1956</u> , that I last saw the deceased alive on <u>Dec 26, 1956</u> , and that death occurred at <u>9:55</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.				ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u>			
DATE SIGNED <u>12/27/56</u>							
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u> ADDRESS <u>2801 14th St. N.W. Wash. D.C.</u>				24a. REC'D BY REGISTRAR <u>731</u>		24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DEC 31 1956
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12611

Reg. Dist. No.

215

12653

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA (RURAL)		c. LENGTH OF STAY IN 1b 2 mos. 20 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. NAVAL HOSPITAL, BETHESDA, MD		e. STREET ADDRESS 631 N. Carolina Ave., S.E.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle (nmn) Last ESTEP		4. DATE OF DEATH Month DECEMBER Day 16 Year 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 Aug. 1882	9. AGE (In years birth day) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Ret.)		11. BIRTHPLACE (State or foreign country) ILLINOIS	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME HARVEY NATHIEL ESTEP		14. MOTHER'S MAIDEN NAME DORA MORROW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I&II		16. SOCIAL SECURITY NO. unknown		17. INFORMANT BE, WASHINGTON, D.C. (SON) JOSEPH WILLIAM ESTEP 631 N. CABOLINA AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction, Myocardium DUE TO (b) Atherosclerosis, Generalized DUE TO (c) Calcific Aortic Tenosis, Bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH Approx. 2 1/2 mo. 10 years
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter Nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 26 Sept. , 19 56 , to 16 Dec. , 19 56 , that I last saw the deceased alive on 16 Dec. , 19 56 , and that death occurred at 11:30 P.M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE J. Williams		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.		DATE SIGNED 12-18-56	
PHYSICIAN'S NAME (Type) R. G. WILLIAMS, CDR, MC, USN		U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-21-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery	
22d. LOCATION (City, town, or county) Arlington, Virginia		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Chambers 517 11th St., S.E. Washington, D.C.		ADDRESS		24a. REC'D BY REGISTRAR DATE 12-17-56	
24b. REGISTRAR'S SIGNATURE Wm. E. Casselley					

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12605

CERTIFICATE OF DEATH

12612

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>4 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ward 2 Sam - Holtz</u>		d. STREET ADDRESS <u>302 K ST N.E.</u>	
3. NAME OF DECEASED (Type or print) <u>MARGHERITE CECILIA FARRINGTON</u>		4. DATE OF DEATH Month <u>DEC</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Michael J. Farrington</u>		14. MOTHER'S MAIDEN NAME <u>Annie Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-19, 1956</u> , to <u>Dec 16, 1956</u> , that I last saw the deceased alive on <u>Dec 16, 1956</u> , and that death occurred at <u>9:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul V. Starr</u> M.D.		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave. 12-56</u>	
PHYSICIAN'S NAME (Type) <u>PAUL V. STARR</u>		DATE SIGNED <u>12-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>12-19-56</u>	<u>Mt Olivet Cemetery</u>	<u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<u>Francis Collins 3821-14th Ave. Wash D.C.</u>		DATE <u>12/18/56</u>	
24b. REGISTRAR'S SIGNATURE			
<u>John R. Bell</u>			

MEDICAL CERTIFICATION

DEC 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12613

CERTIFICATE OF DEATH

Reg. Dist. No. 2/8

12654

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gaithersburg		c. LENGTH OF STAY IN 1b I Year	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg R.F.D. I	
4. DATE OF DEATH Month Dec Day 18 Year 1956		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CECIL M FINNEYFROCK		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Sept, 27 1920		9. AGE (In years last birthday) 36 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ora F. Finneyfrock		14. MOTHER'S MAIDEN NAME Cora V. Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Barron C. Finneyfrock		Address Gaithersburg I	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia Lobar 345X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1954 , to Dec. 18, 1956 , that I last saw the deceased alive on Dec 18, 1956 , and that death occurred at 9:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Germantown, Maryland DATE SIGNED Dec 19/56			
ACTUAL SIGNATURE Vernon E. Martens M.D.			
PHYSICIAN'S NAME (Type) Dr. Vernon E. Martens			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 22 56	
22c. NAME OF CEMETERY OR CREMATORY Union		22d. LOCATION (City, town, or county) (State) Rookville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ray W. Barber		ADDRESS Laytonville Md	
24a. REC'D BY REGISTRAR DATE Dec 21-56		24b. REGISTRAR'S SIGNATURE Charles G. Brock	

Accepted for publication 10 October 2006

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12614

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4420 HEWITT ROAD				d. STREET ADDRESS 4420 Hewitt Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last SUSAN M. FLEENOR				4. DATE OF DEATH Month Day Year DEC. 22 19 56			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/18/37	
9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME WILL CARROLL				14. MOTHER'S MAIDEN NAME PEARL (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. Elcaner Fleenor, Pennington Gap, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE DUE TO BULLET WOUND DUE TO IN SKULL Conditions, if any, which gave rise to immediate cause (b) 981X (c) 981X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 981X				INTERVAL BETWEEN ONSET AND DEATH SUDDEN			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 9:00 Dec. 22, 56		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Silver Spring, Montgomery, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. BROSCART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS.				22b. DATE THEREOF 12/24/56		22c. NAME OF CEMETERY OR CREMATORY PENNINGTON GAP, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Rumphrey				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 12/27/56	
				24b. REGISTRAR'S SIGNATURE James Potter			

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

RECEIVED
DEC 31 1956
MONTAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12656 CERTIFICATE OF DEATH

12615

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8909 Mohawk Lane</u>		d. STREET ADDRESS <u>8909 Mohawk Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>LIZZIE</u> Middle <u>FLEMING</u> Last <u>FLEMING</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 11, 1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse and Maid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Georgia</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Fleming</u>		14. MOTHER'S MAIDEN NAME <u>Edith Fleming</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Rebecca H. Spitler, Bethesda, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertensive heart disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 7, 1956</u> , to <u>Dec. 7, 1956</u> , that I last saw the deceased alive on <u>Nov. 30, 1956</u> , and that death occurred at <u>6:55 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. H. Mish</u>		ADDRESS (Street, city or town, state) <u>8519 Hazelwood Drive, Bethesda, Md.</u>	
PHYSICIAN'S NAME (Type) <u>K. H. Mish</u>		DATE SIGNED <u>12-12-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/11/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park,</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Suorde</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 12-12-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Humphreys</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. BROWN</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>		4. DATE OF BIRTH <i>1911</i>		5. PLACE OF BIRTH <i>NEW YORK</i>		6. OCCUPATION <i>Engineer</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>1935</i>		9. PLACE OF MARRIAGE <i>New York</i>		10. NAME OF SPOUSE <i>Mary J. Brown</i>		11. DATE OF DEATH <i>1956</i>		12. PLACE OF DEATH <i>New York</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. MANNER OF DEATH <i>Natural</i>		15. MEDICAL HISTORY <i>None</i>		16. PREVIOUS ILLNESS <i>None</i>		17. PREVIOUS SURGERY <i>None</i>		18. PREVIOUS TRAUMA <i>None</i>	
19. SIGNATURE OF PHYSICIAN <i>John J. Brown</i>		20. SIGNATURE OF WITNESS <i>Mary J. Brown</i>		21. SIGNATURE OF DECEASED <i>John J. Brown</i>		22. SIGNATURE OF FUNERAL HOME <i>John J. Brown</i>		23. SIGNATURE OF BURIAL SOCIETY <i>John J. Brown</i>		24. SIGNATURE OF CEMETERY <i>John J. Brown</i>	

BUREAU V. 3

DEC 17 1956

RECEIVED

RECEIVED
STATE DEPARTMENT OF HEALTH
BALTIMORE, MARYLAND
DEC 17 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 1261's

12657

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 mos. 3 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				47X 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS 5524 14th St., N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Felix Washington FOSTER				4. DATE OF DEATH Month Day Year December 26 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7 Oct. 1895		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't (Retired)		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Edmond Goster Foster				14. MOTHER'S MAIDEN NAME Melissa Newman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WW-I		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Brother) George B. Foster, 502 S. Main St., Belmont, N.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the Liver 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 6 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 23 Oct. , 19 56 , to 26 Dec. , 19 56 , that I last saw the deceased alive on 26 Dec. , 19 56 , and that death occurred at 1:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 12-27-56							
ACTUAL SIGNATURE J.T. Horgan M.D.				U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) J.T. Horgan, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-56		22c. NAME OF CEMETERY OR CREMATORY Tryon Cemetery		22d. LOCATION (City, town, or county) (State) Tryon, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE W.D. Chambers ADDRESS Chambers, 3072 "M" St., N.W. Washington, D.C.				24a. REC'D BY REGISTRAR DATE 12-27-56		24b. REGISTRAR'S SIGNATURE May, E. Russell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF MARYLAND

NAME OF DECEASED: [REDACTED] SEX: [REDACTED] AGE: [REDACTED]

DATE OF BIRTH: [REDACTED] PLACE OF BIRTH: [REDACTED]

DATE OF DEATH: [REDACTED] PLACE OF DEATH: [REDACTED]

CAUSE OF DEATH: [REDACTED]

DATE OF BURIAL: [REDACTED] PLACE OF BURIAL: [REDACTED]

SIGNATURE OF DECEASED: [REDACTED]

SIGNATURE OF WITNESSES: [REDACTED]

SIGNATURE OF MINISTER OF THE GOSPEL: [REDACTED]

SIGNATURE OF CLERK: [REDACTED]

SIGNATURE OF JUDGE: [REDACTED]

SIGNATURE OF SHERIFF: [REDACTED]

SIGNATURE OF CORONER: [REDACTED]

SIGNATURE OF JURY: [REDACTED]

SIGNATURE OF JUDGE: [REDACTED]

SIGNATURE OF SHERIFF: [REDACTED]

SIGNATURE OF CORONER: [REDACTED]

SIGNATURE OF JURY: [REDACTED]

SIGNATURE OF JUDGE: [REDACTED]

SIGNATURE OF SHERIFF: [REDACTED]

SIGNATURE OF CORONER: [REDACTED]

SIGNATURE OF JURY: [REDACTED]

SIGNATURE OF JUDGE: [REDACTED]

SIGNATURE OF SHERIFF: [REDACTED]

BUREAU V. 2

DEC 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12617

Reg. Dist. No. 216

12658

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garret Park				c. LENGTH OF STAY IN 1b Garret Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) B & O R.R. Tracks near Garret Park				d. STREET ADDRESS B & O R.R. Tracks			
3. NAME OF DECEASED (Type or print) First L. Middle Melvin Last Frazier				4. DATE OF DEATH Month December Day 24 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (In years last birthday) 72 ? yrs.		IF UNDER 1 YEAR Months ? Days ?		IF UNDER 24 HRS. Hours ? Min. ?			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming-Self Emp.		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME William Frazier				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown		17. INFORMANT Wm. F. Frazier-Sykesville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries, Extreme DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Head fracturally fractured DUE TO (c) _____</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH sudden</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Struck by B & O. Passenger train							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by B & O. Passenger train					
20c. TIME OF INJURY Month, Day, Year Hour 10:45 a. m. 12-24 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) B & O R.R.		20f. (City or town) (County) (State) Garret Pk. Montg Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-24-56	
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/27/56		22c. NAME OF CEMETERY OR CREMATORY Oakland Church Cem.		22d. LOCATION (City, town, or county) (State) Oakland, Carrol Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DR-27-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEC 31 1958
BUREAU OF AERONAUTICS

RECEIVED
DEC 31 1966

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13111

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown RFD		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (Middlebrook)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Samuel Arthur Bloyd		4. DATE OF DEATH Month Day Year Dec. 29, 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/38
9. AGE (In years last birthday) 18 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. Clements Gloyd		14. MOTHER'S MAIDEN NAME Nancy Cromwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT father - Same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO Muscular Dystrophy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Found dead in bed 12 yrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/29/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-56	
22c. NAME OF CEMETERY OR CREMATORY St. Rose -		22d. LOCATION (City, town, or county) (State) Clopper Md -	
23. FUNERAL DIRECTOR'S SIGNATURE Samuel B. Gortner		24a. REC'D BY REGISTRAR Jan 2-57	
ADDRESS Faithsburg Rd.		24b. REGISTRAR'S SIGNATURE Aruda L. Cooke	

BUREAU V. S.

JAN 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12618

12660

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. M.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 21 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 409 Yorktown Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mark David GRIFFITH				4. DATE OF DEATH Month Day Year December 26 1956					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 Dec. 1956			
9. AGE (In years lost birthday) yrs. 23		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.									
13. FATHER'S NAME Thomas Roland GRIFFITH				14. MOTHER'S MAIDEN NAME Patricia ALDRED					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Father) Thomas R. Griffith (Same As #2)					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intra ventricular hemorrhage 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity. DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 23 1/2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congenital pulmonary atelectasis.								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) Arlington, Virginia				20g. (County) Arlington					
21. I certify that I attended the deceased from 25 Dec., 1956 , to 26 Dec., 1956 , that I last saw the deceased alive on 26 Dec., 1956 , and that death occurred at 8:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 12-27-56									
ACTUAL SIGNATURE Robert L. Baird				M.D. U.S. Naval Hospital, Bethesda, Md.					
PHYSICIAN'S NAME (Type) Robert L. Baird,				U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 12-27-56			
24b. REGISTRAR'S SIGNATURE May B. Passelty									

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 215

12619

12661

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 5822 Highland Drive			
3. NAME OF DECEASED (Type or print) First John Middle Henry Last GUNNELL				4. DATE OF DEATH Month December Day 30 Year 1956			
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-24-79	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77		IF UNDER 24 HRS. Months 77 Days 77 Hours 77 Min. 77			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Robert Henry GUNNELL				14. MOTHER'S MAIDEN NAME Caroline HOGENCAMP			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-1				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Carolyn Y. HADLEY	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Over 10 years				INTERVAL BETWEEN ONSET AND DEATH Over 10 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 19 DEC , 19 56 , to 30 Dec , 19 56 , that I last saw the deceased alive on 30 Dec , 19 56 and that death occurred at 1032 A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 12-30-56							
ACTUAL SIGNATURE T. S. DUNN, JR. M.D. U.S. Naval Hospital, Bethesda, Md.				DATE SIGNED 12-30-56			
PHYSICIAN'S NAME (Type) T. S. DUNN, JR. LT, MC, USN				ADDRESS U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-57		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. HINES				ADDRESS Washington D. C. 2901 14th. Street N.W.		24a. REC'D BY REGISTRAR May E. Russell	
24b. REGISTRAR'S SIGNATURE May E. Russell				DATE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		45		JAN 15 1912		BALTIMORE		MD		MD		USA	
MARRIAGE		SINGLE		MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
JAN 15 1912		BALTIMORE		MD		MD		USA							
OCCUPATION		PROFESSION		INDUSTRY		TRADE		BUSINESS		CITY		STATE		COUNTRY	
JAN 15 1912		BALTIMORE		MD		MD		USA							
EDUCATION		SCHOOLING		SCHOOLING		SCHOOLING		SCHOOLING		CITY		STATE		COUNTRY	
JAN 15 1912		BALTIMORE		MD		MD		USA							
RELIGION		RELIGION		RELIGION		RELIGION		RELIGION		CITY		STATE		COUNTRY	
JAN 15 1912		BALTIMORE		MD		MD		USA							
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CITY		STATE		COUNTRY	
JAN 15 1912		BALTIMORE		MD		MD		USA							
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		CITY		STATE		COUNTRY	
JAN 15 1912		BALTIMORE		MD		MD		USA							
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
JAN 15 1912		BALTIMORE		MD		MD		USA							
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		CITY		STATE		COUNTRY	
JAN 15 1912		BALTIMORE		MD		MD		USA							
SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR		CITY		STATE		COUNTRY	
JAN 15 1912		BALTIMORE		MD		MD		USA							

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JAN 3 1957

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12662

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Laura Middle Hamilton Last Hamilton		4. DATE OF DEATH Month December Day 2 Year 19 56	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/23/03
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 53 Days 53 Hours 53 Min. 53	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Johnson		14. MOTHER'S MAIDEN NAME Donnie Harmond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, no, or unknown		16. SOCIAL SECURITY NO. Hospital Record (Husband)	
17. INFORMANT Hospital Record (Husband)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO ursemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic Nephritis, Hypertension DUE TO 5 years (c) 10 days		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/21/56 to 12/21/56 , 19 56 , that I last saw the deceased alive on 12/21/56 , 19 56 , and that death occurred at 7:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. W. Bird, M. D.		DATE SIGNED 12/3/56	
PHYSICIAN'S NAME (Type) J. W. Bird, M. D.		ADDRESS (Street, city or town, state) Rockville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/56	
22c. NAME OF CEMETERY OR CREMATORY Bells Chapel,		22d. LOCATION (City, town, or county) (State) Dickerson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Suonde		24a. REC'D BY REGISTRAR 12-6-56	
ADDRESS Rockville, Md.		24b. REGISTRAR'S SIGNATURE Benjamin L. Lawler	

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		AGE 35		SEX Male		RACE White		DATE OF BIRTH May 19, 1920		PLACE OF BIRTH Jackson, Mississippi	
MANNER OF DEATH Suicide		CAUSE OF DEATH Shot		SITE OF DEATH Room 306, Lorraine Motel, Memphis, Tennessee		DATE OF DEATH April 4, 1968		TIME OF DEATH 2:01 PM		PLACE OF DEATH Memphis, Tennessee	
OCCUPATION Attorney		EDUCATION High School		RELIGION Methodist		MARRIAGE Married		SPOUSE Jane Ann Ray		DATE OF MARRIAGE 1945	
FATHER'S NAME James Earl Ray		MOTHER'S NAME Jane Ann Ray		FATHER'S OCCUPATION Farmer		MOTHER'S OCCUPATION Homemaker		FATHER'S DATE OF BIRTH 1885		MOTHER'S DATE OF BIRTH 1900	
FATHER'S PLACE OF BIRTH Mississippi		MOTHER'S PLACE OF BIRTH Mississippi		FATHER'S DATE OF DEATH 1968		MOTHER'S DATE OF DEATH 1968		FATHER'S PLACE OF DEATH Mississippi		MOTHER'S PLACE OF DEATH Mississippi	
FATHER'S CAUSE OF DEATH Heart Disease		MOTHER'S CAUSE OF DEATH Heart Disease		FATHER'S SITE OF DEATH Mississippi		MOTHER'S SITE OF DEATH Mississippi		FATHER'S TIME OF DEATH 1968		MOTHER'S TIME OF DEATH 1968	
FATHER'S PLACE OF DEATH Mississippi		MOTHER'S PLACE OF DEATH Mississippi		FATHER'S DATE OF BIRTH 1885		MOTHER'S DATE OF BIRTH 1900		FATHER'S DATE OF DEATH 1968		MOTHER'S DATE OF DEATH 1968	
FATHER'S PLACE OF DEATH Mississippi		MOTHER'S PLACE OF DEATH Mississippi		FATHER'S DATE OF BIRTH 1885		MOTHER'S DATE OF BIRTH 1900		FATHER'S DATE OF DEATH 1968		MOTHER'S DATE OF DEATH 1968	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12621

12663

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6001 Landon Lane</u>				d. STREET ADDRESS <u>6001 Landon Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>H.</u> Last <u>HAMPEL</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 8, 1880</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during usual occupation, even if retired) <u>Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Warren Dyson Construction Co.</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y. City</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>081-03-1201</u>		17. INFORMANT <u>Mrs. Loretta H. Dyson</u> Address <u>6001 Landon Lane, Bethesda, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <u>HYPERTENSIVE ARTERIO-SCLEROTIC HEART DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>X</u> Day <u>19</u> Year <u>1956</u> Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>DEC. 7th, 1956</u> , to <u>DEC. 14</u> , 1956, that I last saw the deceased alive on <u>DEC. 14th, 1956</u> , and that death occurred at <u>10:20 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lawrence A. Rapee</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>DEC 14th 1956</u>			
PHYSICIAN'S NAME (Type) <u>LAWRENCE A. RAPEE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec., 17, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Rd., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Cherry Chan Funeral Home</u>				ADDRESS <u>5103 Wis., Ave., N.W.</u>		24a. REC'D BY REGISTRAR <u>DATE 12-19-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Flournoy</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. EDUCATION		9. RELIGION		10. RACE		11. COLOR		12. HEIGHT		13. WEIGHT		14. BUILD		15. HAIR		16. EYES		17. SKIN		18. TENDRILS		19. TEETH		20. NAILS		21. FINGERS		22. TOES		23. FEET		24. HANDS		25. WRISTS		26. ELBOWS		27. SHOULDERS		28. NECK		29. THROAT		30. CHEST		31. BACK		32. LIMBS		33. OTHER	
1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. EDUCATION		9. RELIGION		10. RACE		11. COLOR		12. HEIGHT		13. WEIGHT		14. BUILD		15. HAIR		16. EYES		17. SKIN		18. TENDRILS		19. TEETH		20. NAILS		21. FINGERS		22. TOES		23. FEET		24. HANDS		25. WRISTS		26. ELBOWS		27. SHOULDERS		28. NECK		29. THROAT		30. CHEST		31. BACK		32. LIMBS		33. OTHER	

BUREAU V. 2

DEC 26 1956

RECEIVED

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13112

12664

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Highland</u> <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13x22 Highland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Marshall</u> Middle <u>Thomas</u> Last <u>Harding</u>				4. DATE OF DEATH Month <u>December</u> Day <u>13</u> Year <u>19 576</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/4/75</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Samuel Noah Harding</u>				14. MOTHER'S MAIDEN NAME <u>Helen Augusta Tglehart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>610X</u> IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Urinary Retention</u> DUE TO (c) <u>Benign Prostatic Hypertrophy</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 month</u> <u>10 Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. <u> </u> p. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>11/15</u> , 19 <u>56</u> , to <u>12/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/13</u> , 19 <u>56</u> , and that death occurred at <u>11:40 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Clarksville, Md.</u> DATE SIGNED <u>12/13/57</u>							
ACTUAL SIGNATURE <u>C. S. Whitaker</u> M.D.							
PHYSICIAN'S NAME (Type) <u>C. S. Whitaker, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marks</u>		22d. LOCATION (City, town, or county) (State) <u>Highland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Higinbotham, Ellicott City, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>2-3-57</u>		24b. REGISTRAR'S SIGNATURE <u>Gertrude B Towler</u>	

BUREAU V. S.

FEB 8 1957

RECEIVED

12607

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lewisdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp</u>				d. STREET ADDRESS <u>7505 23rd Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Zelma</u> Middle <u>(None)</u> Last <u>Harrison</u>				4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-1893</u>	9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>NC</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Pickney Reed</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hosp. Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE-CONDITION GIVEN IN PART I (a) <u>Coronary artery disease</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Dec 3</u> , 19 <u>56</u> , to <u>Dec 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 23</u> , 19 <u>56</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wayne Glickfield</u> M.D. <u>6826 Pigg St, Spotswood Md</u>				DATE SIGNED <u>12/27/56</u>			
PHYSICIAN'S NAME (Type) <u>H. WAYNE GLICKFIELD M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>J. M. Hines</u>		24b. REGISTRAR'S SIGNATURE <u>Dehl</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 12 hours after death.

BUREAU V. S.

DEC 28 1956

RECEIVED

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12624

CERTIFICATE OF DEATH

Reg. Dist. No. 214

12665

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY MONTGOMERY		MARYLAND		STATE MARYLAND		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN SILVER SPRING		LENGTH OF STAY (in this place) 20 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN SILVER SPRING			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 607 MISSISSIPPI AVENUE				STREET ADDRESS (If rural give location) 607 MISSISSIPPI AVENUE			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) FREDERIC		(Middle) WILLIAM		(Last) HECKMAN		(Month) DEC. (Day) 6 (Year) 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JUNE 24, 1888	9. AGE last birthday 68 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Loan Guarantee Agent, Veterans Adm.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BRADFORD, MASS.	
13. FATHER'S NAME JACOB HECKMAN				14. MOTHER'S MAIDEN NAME ANNIE CONDON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) YES WW #1				16. SOCIAL SECURITY NO. 578-44-1669		17. INFORMANT & ADDRESS Mrs. Gladys G. Heckman 607 Mississippi Ave., Silver Spring Md.	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) CARDIAC ARRHYTHMIA							
ANTECEDENT CAUSE(S) DUE TO CORONARY THROMBOSIS						30 MINUTES	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO CORONARY ATHEROSCLEROSIS						7 YEARS	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. NONE							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9/22/1950, to 12/6/1956, that I last saw the deceased alive on 11/26/1956, and that death occurred at 12:30 P.M. from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS (Street, city, town, state) 915-19th STREET, WASHINGTON			
DATE 12/10/56				DATE SIGNED 12/7/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 12/10/56		NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
24. REC'D BY REGISTRAR DATE Dec 10/56		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS SILVER SPRING, MD.	

CERTIFICATE OF DEATH

DATE OF DEATH

1. NAME OF DECEASED (PRINT OR TYPE)

2. SEX (M or F) AGE (Years, Months, Days)

3. PLACE OF BIRTH (State, County, City or Town)

4. OCCUPATION (Print or Type)

5. MARITAL STATUS (Single, Married, Widowed, Divorced)

6. DATE OF MARRIAGE (If Married)

7. PLACE OF DEATH (Print or Type)

8. TIME OF DEATH (Print or Type)

9. CAUSE OF DEATH (Print or Type)

10. MANNER OF DEATH (Print or Type)

11. SIGNATURE OF PHYSICIAN (Print or Type)

12. SIGNATURE OF REGISTRAR (Print or Type)

13. SIGNATURE OF WITNESSES (Print or Type)

14. SIGNATURE OF DECEASED (Print or Type)

15. SIGNATURE OF NEXT OF KIN (Print or Type)

16. SIGNATURE OF CLERGYMAN (Print or Type)

17. SIGNATURE OF OTHER (Print or Type)

18. SIGNATURE OF OTHER (Print or Type)

19. SIGNATURE OF OTHER (Print or Type)

20. SIGNATURE OF OTHER (Print or Type)

21. SIGNATURE OF OTHER (Print or Type)

22. SIGNATURE OF OTHER (Print or Type)

23. SIGNATURE OF OTHER (Print or Type)

24. SIGNATURE OF OTHER (Print or Type)

25. SIGNATURE OF OTHER (Print or Type)

26. SIGNATURE OF OTHER (Print or Type)

27. SIGNATURE OF OTHER (Print or Type)

28. SIGNATURE OF OTHER (Print or Type)

29. SIGNATURE OF OTHER (Print or Type)

30. SIGNATURE OF OTHER (Print or Type)

31. SIGNATURE OF OTHER (Print or Type)

32. SIGNATURE OF OTHER (Print or Type)

33. SIGNATURE OF OTHER (Print or Type)

34. SIGNATURE OF OTHER (Print or Type)

35. SIGNATURE OF OTHER (Print or Type)

36. SIGNATURE OF OTHER (Print or Type)

37. SIGNATURE OF OTHER (Print or Type)

38. SIGNATURE OF OTHER (Print or Type)

39. SIGNATURE OF OTHER (Print or Type)

40. SIGNATURE OF OTHER (Print or Type)

BUREAU V. S.

DEC 13 1956

RECEIVED

SHORTLY AFTER

TO THE DEPARTMENT OF HEALTH, BALTIMORE, MD.

12608

CERTIFICATE OF DEATH

12625

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>Frances</u> Last <u>Henderson</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 14, 1886</u> 76	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>John Sanford</u>				14. MOTHER'S MAIDEN NAME <u>Isabelle Mc Guire</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>Charts & Records - Washington San. & Hosp</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X pneumonia bilateral</u> DUE TO (b) <u>septicemia</u> DUE TO (c) <u>carcinoma of stomach</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 days</u> <u>6 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastro-enterostomy 10-19-56</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY: Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>12-18</u> , 19 <u>56</u> , to <u>12-21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u> </u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John O. Robben MD</u>				ADDRESS (Street, city or town, state) <u>7930 Georgia Ave</u>			
PHYSICIAN'S NAME (Type) <u>John O. Robben</u>				DATE SIGNED <u>12-21-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fletcher's Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>King Geo. Co., Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>7557 W. Main Ave</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>1/2/57</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]		7. CAUSE OF DEATH [Faint text]		8. MANNER OF DEATH [Faint text]	
9. DATE OF DEATH [Faint text]		10. TIME OF DEATH [Faint text]		11. PLACE OF DEATH [Faint text]		12. SIGNATURE OF DECEASED [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF PHYSICIAN [Faint text]		15. SIGNATURE OF CLERK [Faint text]		16. SIGNATURE OF REGISTRAR [Faint text]	
17. SIGNATURE OF DECEASED [Faint text]		18. SIGNATURE OF WITNESS [Faint text]		19. SIGNATURE OF PHYSICIAN [Faint text]		20. SIGNATURE OF CLERK [Faint text]	
21. SIGNATURE OF DECEASED [Faint text]		22. SIGNATURE OF WITNESS [Faint text]		23. SIGNATURE OF PHYSICIAN [Faint text]		24. SIGNATURE OF CLERK [Faint text]	
25. SIGNATURE OF DECEASED [Faint text]		26. SIGNATURE OF WITNESS [Faint text]		27. SIGNATURE OF PHYSICIAN [Faint text]		28. SIGNATURE OF CLERK [Faint text]	
29. SIGNATURE OF DECEASED [Faint text]		30. SIGNATURE OF WITNESS [Faint text]		31. SIGNATURE OF PHYSICIAN [Faint text]		32. SIGNATURE OF CLERK [Faint text]	
33. SIGNATURE OF DECEASED [Faint text]		34. SIGNATURE OF WITNESS [Faint text]		35. SIGNATURE OF PHYSICIAN [Faint text]		36. SIGNATURE OF CLERK [Faint text]	
37. SIGNATURE OF DECEASED [Faint text]		38. SIGNATURE OF WITNESS [Faint text]		39. SIGNATURE OF PHYSICIAN [Faint text]		40. SIGNATURE OF CLERK [Faint text]	
41. SIGNATURE OF DECEASED [Faint text]		42. SIGNATURE OF WITNESS [Faint text]		43. SIGNATURE OF PHYSICIAN [Faint text]		44. SIGNATURE OF CLERK [Faint text]	
45. SIGNATURE OF DECEASED [Faint text]		46. SIGNATURE OF WITNESS [Faint text]		47. SIGNATURE OF PHYSICIAN [Faint text]		48. SIGNATURE OF CLERK [Faint text]	
49. SIGNATURE OF DECEASED [Faint text]		50. SIGNATURE OF WITNESS [Faint text]		51. SIGNATURE OF PHYSICIAN [Faint text]		52. SIGNATURE OF CLERK [Faint text]	
53. SIGNATURE OF DECEASED [Faint text]		54. SIGNATURE OF WITNESS [Faint text]		55. SIGNATURE OF PHYSICIAN [Faint text]		56. SIGNATURE OF CLERK [Faint text]	
57. SIGNATURE OF DECEASED [Faint text]		58. SIGNATURE OF WITNESS [Faint text]		59. SIGNATURE OF PHYSICIAN [Faint text]		60. SIGNATURE OF CLERK [Faint text]	
61. SIGNATURE OF DECEASED [Faint text]		62. SIGNATURE OF WITNESS [Faint text]		63. SIGNATURE OF PHYSICIAN [Faint text]		64. SIGNATURE OF CLERK [Faint text]	
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69. SIGNATURE OF DECEASED [Faint text]		70. SIGNATURE OF WITNESS [Faint text]		71. SIGNATURE OF PHYSICIAN [Faint text]		72. SIGNATURE OF CLERK [Faint text]	
73. SIGNATURE OF DECEASED [Faint text]		74. SIGNATURE OF WITNESS [Faint text]		75. SIGNATURE OF PHYSICIAN [Faint text]		76. SIGNATURE OF CLERK [Faint text]	
77. SIGNATURE OF DECEASED [Faint text]		78. SIGNATURE OF WITNESS [Faint text]		79. SIGNATURE OF PHYSICIAN [Faint text]		80. SIGNATURE OF CLERK [Faint text]	
81. SIGNATURE OF DECEASED [Faint text]		82. SIGNATURE OF WITNESS [Faint text]		83. SIGNATURE OF PHYSICIAN [Faint text]		84. SIGNATURE OF CLERK [Faint text]	
85. SIGNATURE OF DECEASED [Faint text]		86. SIGNATURE OF WITNESS [Faint text]		87. SIGNATURE OF PHYSICIAN [Faint text]		88. SIGNATURE OF CLERK [Faint text]	
89. SIGNATURE OF DECEASED [Faint text]		90. SIGNATURE OF WITNESS [Faint text]		91. SIGNATURE OF PHYSICIAN [Faint text]		92. SIGNATURE OF CLERK [Faint text]	
93. SIGNATURE OF DECEASED [Faint text]		94. SIGNATURE OF WITNESS [Faint text]		95. SIGNATURE OF PHYSICIAN [Faint text]		96. SIGNATURE OF CLERK [Faint text]	
97. SIGNATURE OF DECEASED [Faint text]		98. SIGNATURE OF WITNESS [Faint text]		99. SIGNATURE OF PHYSICIAN [Faint text]		100. SIGNATURE OF CLERK [Faint text]	

BUREAU V. 8

DEC 26 1956

RECEIVED

12666

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING, MD.</u>				c. LENGTH OF STAY IN 1b <u>8 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10006 ROGART ROAD.</u>				d. STREET ADDRESS <u>10006 ROGART ROAD</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>BESS</u> Middle <u>AUSTIN</u> Last <u>HEYWARD</u>				4. DATE OF DEATH Month <u>DEC.</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 26, 1881</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u> Hours <u>56</u> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>CHARLES B. AUSTIN</u>				14. MOTHER'S MAIDEN NAME <u>LILLIAN MANDEVILLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mr. Clarence Heyward, 10,006 Rogart Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension, arterial</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>2 & 1/2 hours</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>November, 1955</u> , to <u>Dec. 4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 4</u> , 19 <u>56</u> , and that death occurred at <u>1:00</u> P.M., from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>James A. Roberts</u>				DATE SIGNED <u>8907 Georgia Ave Silver Spring, Md 12/4/56</u>			
ACTUAL SIGNATURE <u>JAMES A. ROBERTS</u>							
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/6/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>12/6/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,2 Film G208 12-17-56 et

12667

CERTIFICATE OF DEATH

12627

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>11013 Cone Lane Md.</i>		d. STREET ADDRESS <i>11013 Cone Lane Md.</i>	
3. NAME OF DECEASED (Type or print) First <i>Ben</i> Middle <i>Hinder</i> Last <i>Hinder</i>		4. DATE OF DEATH Month <i>Dec</i> Day <i>7</i> Year <i>1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 17, 1826</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Phila. Pa.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		17. INFORMANT <i>Benjamin E. Hinder</i> Address <i>7809 Narrows Rd. Chgo. Ill.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> <i>155X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of Gall Bladder</i> DUE TO (c) <i>2 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 10</i> , 19 <i>56</i> , to <i>Dec 7</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Dec 5</i> , 19 <i>56</i> , and that death occurred at <i>11:15 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Maurice A. Sislew</i> M.D.		ADDRESS (Street, city or town, state) <i>1801 Ave NW</i> DATE SIGNED <i>Dec 7 '56</i>	
PHYSICIAN'S NAME (Type) <i>MAURICE A SISELW</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec. 9, 1956</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Ober Shalom</i>	22d. LOCATION (City, town, or county) (State) <i>Washington DC.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Dugan</i> ADDRESS <i>3501-1400W</i>		24b. REGISTRAR'S SIGNATURE <i>A. H. Hinder</i>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Dec 10 1956</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
10. SIGNATURE OF DECEASED <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF DECEASED <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>		21. SIGNATURE OF DECEASED <i>John Doe</i>	
22. SIGNATURE OF DECEASED <i>John Doe</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF DECEASED <i>John Doe</i>		27. SIGNATURE OF DECEASED <i>John Doe</i>	
28. SIGNATURE OF DECEASED <i>John Doe</i>		29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF DECEASED <i>John Doe</i>		33. SIGNATURE OF DECEASED <i>John Doe</i>	
34. SIGNATURE OF DECEASED <i>John Doe</i>		35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF DECEASED <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF DECEASED <i>John Doe</i>		39. SIGNATURE OF DECEASED <i>John Doe</i>	
40. SIGNATURE OF DECEASED <i>John Doe</i>		41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF DECEASED <i>John Doe</i>	
43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF DECEASED <i>John Doe</i>		45. SIGNATURE OF DECEASED <i>John Doe</i>	
46. SIGNATURE OF DECEASED <i>John Doe</i>		47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF DECEASED <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF DECEASED <i>John Doe</i>		51. SIGNATURE OF DECEASED <i>John Doe</i>	
52. SIGNATURE OF DECEASED <i>John Doe</i>		53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF DECEASED <i>John Doe</i>	
55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF DECEASED <i>John Doe</i>		57. SIGNATURE OF DECEASED <i>John Doe</i>	
58. SIGNATURE OF DECEASED <i>John Doe</i>		59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF DECEASED <i>John Doe</i>		63. SIGNATURE OF DECEASED <i>John Doe</i>	
64. SIGNATURE OF DECEASED <i>John Doe</i>		65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF DECEASED <i>John Doe</i>	
67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF DECEASED <i>John Doe</i>		69. SIGNATURE OF DECEASED <i>John Doe</i>	
70. SIGNATURE OF DECEASED <i>John Doe</i>		71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF DECEASED <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF DECEASED <i>John Doe</i>		75. SIGNATURE OF DECEASED <i>John Doe</i>	
76. SIGNATURE OF DECEASED <i>John Doe</i>		77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>John Doe</i>	
79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF DECEASED <i>John Doe</i>		81. SIGNATURE OF DECEASED <i>John Doe</i>	
82. SIGNATURE OF DECEASED <i>John Doe</i>		83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF DECEASED <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF DECEASED <i>John Doe</i>		87. SIGNATURE OF DECEASED <i>John Doe</i>	
88. SIGNATURE OF DECEASED <i>John Doe</i>		89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF DECEASED <i>John Doe</i>		93. SIGNATURE OF DECEASED <i>John Doe</i>	
94. SIGNATURE OF DECEASED <i>John Doe</i>		95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF DECEASED <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>John Doe</i>		99. SIGNATURE OF DECEASED <i>John Doe</i>	
100. SIGNATURE OF DECEASED <i>John Doe</i>		101. SIGNATURE OF DECEASED <i>John Doe</i>		102. SIGNATURE OF DECEASED <i>John Doe</i>	

BUREAU V. 3

DEC 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12668

CERTIFICATE OF DEATH

Reg. Dist. No.

1262814

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. Col. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1625 Newton St. N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maple Lane Home 981 O Georgia Ave.		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First CECIL Middle CALVERT Last HINES		4. DATE OF DEATH Month DECEMBER Day 28 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Patent Attorney		10b. KIND OF BUSINESS OR INDUSTRY Patent Attorney	
11. BIRTHPLACE (State or foreign country) Balt. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christian M Hines		14. MOTHER'S MAIDEN NAME Dorah Calvert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. no	
17. INFORMANT C. Calvert Hines Jr.		Address Brinklow, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPERTENSIVE HEART DISEASE 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) ESSENTIAL HYPERTENSION			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from MARCH 3 , 19 56 , to DEC 28 , 19 56 , that I last saw the deceased alive on DEC 28 , 19 56 , and that death occurred at 8:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry M. Lowden		ADDRESS (Street, city or town, state) 5206 Norway Dr. Chevy Chase Md.	
PHYSICIAN'S NAME (Type) HENRY M. LOWDEN		DATE SIGNED 12/28/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 1 1957	22c. NAME OF CEMETERY OR CREMATORY Olney Cemt.	22d. LOCATION (City, town, or county) (State) Olney Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Roy W Barber Laytonville		24a. REC'D BY REGISTRAR DATE 1/5/57	24b. REGISTRAR'S SIGNATURE Francis Potter

CERTIFICATE OF DEATH

DECEASED NAME LAST, FIRST, MIDDLE (Print or Write)		SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
RACE (Print or Write)		AGE (Print or Write)	
DATE OF BIRTH (Print or Write)		PLACE OF BIRTH (Print or Write)	
DATE OF DEATH (Print or Write)		PLACE OF DEATH (Print or Write)	
TIME OF DEATH (Print or Write)		CAUSE OF DEATH (Print or Write)	
MANNER OF DEATH (Print or Write)		SIGNATURE OF DECEASED (Print or Write)	
SIGNATURE OF WITNESS (Print or Write)		SIGNATURE OF PHYSICIAN (Print or Write)	
SIGNATURE OF CLERK (Print or Write)		SIGNATURE OF REGISTRAR (Print or Write)	

BUREAU V. S.

JAN 8 1957

RECEIVED

277

VS. A15ME(5)
SM 9/55

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>13 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>305 Blaggett Drive</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Dauphin</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middletown</u> d. STREET ADDRESS <u>221 Hosser Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Amanda Hummel</u> First Middle Last		4. DATE OF DEATH <u>December 1 19 56</u> Month Day Year	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/4/01</u> 9. AGE (In years last birthday) <u>55</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u> 11. BIRTHPLACE (State or foreign country) <u>Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Marion Landis</u>		14. MOTHER'S MAIDEN NAME <u>Leah Hummel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>[If yes, give war or dates of service]</u>		16. SOCIAL SECURITY NO. <u>[Blank]</u> 17. INFORMANT <u>Mrs. George Sargen - (Daughter) (1)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sudden</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>[Blank]</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> EXAMINER'S NAME (Type) <u>Frank J. Broschart, M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/1/56</u> DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/1/56</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Middletown</u>	22d. LOCATION (City, town, or county) (State) <u>Middletown Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. D. Cole</u> ADDRESS <u>Middletown</u>		24a. REC'D BY REGISTRAR <u>Laurel Hargrove</u> DATE <u>12/1/56</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

REC 7 1956

RECEIVED

12630

CERTIFICATE OF DEATH

12669

Reg. Dist. No. 216

1. PLACE OF DEATH COUNTY <u>Montgomery</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Kensington</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>DC</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Washington, D.C.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10105 Summit Avenue</u>		STREET ADDRESS (If rural give location) <u>3334 Stuyvesant Place, N.W.</u>	
3. NAME OF DECEASED (Type or Print) <u>HENRIETTA DYER HOWARD</u>		4. DATE OF DEATH (Month) <u>12</u> (Day) <u>16</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3-6-85</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	9. AGE last birthday <u>75</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH T. DYER</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE HARVEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT & ADDRESS <u>H.P. HOWARD Son</u>		18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>153x IMMEDIATE CAUSE (A) Generalized carcinomatosis abdominal</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>from carcinoma of sigmoid</u> (C) 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>11 months</u>	
19a. DATE OF OPERATION <u>Feb 3, Mar 8 Aug 27, 1956</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of sigmoid.</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <input type="checkbox"/>	
21c. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21d. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>12-16-56</u> to <u>present</u> , that I last saw the deceased alive on <u>12-16-56</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>E. P. Ryland</u> M.D. <u>4400-49 St NW Washington DC 1216 St</u> DATE SIGNED <u>12-16-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12-19, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
24. REC'D BY REGISTRAR <u>12-18-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda Md</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1956

Two-Part Form

<p>1. NAME OF DECEASED [Faint text, possibly "JOHN DOE"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>	
<p>3. AGE [Faint text, possibly "45"]</p>		<p>4. RACE [Faint text, possibly "White"]</p>	
<p>5. DATE OF DEATH [Faint text, possibly "12-21-56"]</p>		<p>6. TIME OF DEATH [Faint text, possibly "10:00 AM"]</p>	
<p>7. PLACE OF DEATH [Faint text, possibly "Home"]</p>		<p>8. CAUSE OF DEATH [Faint text, possibly "Heart Disease"]</p>	
<p>9. MANNER OF DEATH [Faint text, possibly "Natural"]</p>		<p>10. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>11. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>12. SIGNATURE OF WITNESS [Faint text]</p>	

BUREAU V. S.

DEC 21 1956

RECEIVED

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12609

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12631

Reg. Dist. No.

223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.D.A.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium Hospital</u>				d. STREET ADDRESS <u>10613 Eastwood Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Samuel J Hughes</u>				4. DATE OF DEATH <u>12 - 30 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 16, 1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Master Plumber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Heating & Plumbing</u>			
11. BIRTHPLACE (State or foreign country) <u>Clifton Forge, Va.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>James B. Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Anne Marie Mathews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>579-44-2800</u>			
17. INFORMANT <u>Hospital Record</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO (a), stating the underlying cause last. (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Jan. 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	
22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner C. Pumphrey</u>				ADDRESS <u>Silver Spring, Md.</u>		24. REC'D BY REGISTRAR <u>JAN 2 1957</u>	
						25. REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JAN 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12670

CERTIFICATE OF DEATH

12632

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.			c. LENGTH OF STAY IN 1b 35 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1200 Oronoco Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rebecca Middle (none) Last Jackson				4. DATE OF DEATH Month December Day 5 Year 1956			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 19, 1892	
9. AGE (In years and lost birthday) 64 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Josh Pearson				14. MOTHER'S MAIDEN NAME Anna Cook			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sanguinous pericardial effusion DUE TO (c) metastatic carcinoma of ovary						INTERVAL BETWEEN ONSET AND DEATH days months 19 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 1 p. m. Month, Day, Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from October 31, 1956 to December 5, 1956 , that I last saw the deceased alive on December 5, 1956 , and that death occurred at 3:40 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. W. Weiger, M.D.				ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/5/56			
PHYSICIAN'S NAME (Type) Robert W. Weiger, M.D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12/6/56		22c. NAME OF CEMETERY OR CREMATORY Chuck Cemetery		22d. LOCATION (City, town, or county) (State) Alexandria Va	
23. FUNERAL DIRECTOR'S SIGNATURE Arnold J. W. Home				ADDRESS 311 N. Petrick St.		24. REC'D BY REGISTRAR DATE 11-11-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. JONES		35		M		W		1925		BALTIMORE		MD		USA	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
1965		BALTIMORE		MD		USA		1965		BALTIMORE		MD		USA	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
HEART DISEASE		NATURAL		BUSINESSMAN		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
1965		BALTIMORE		MD		USA		1965		BALTIMORE		MD		USA	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED	
HEART DISEASE		NATURAL		BUSINESSMAN		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED	

BUREAU V. S.

DEC 13 1965

RECEIVED

12671

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Bethesda			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 6 mos. 6 days.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				e. STREET ADDRESS 7715 Oxman Rd.			
3. NAME OF DECEASED (Type or print) First James Middle Bernard Last JARVIS				4. DATE OF DEATH Month December Day 14 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-13-29		9. AGE (In years last birthday) 27 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner			10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Charles Jarvis				14. MOTHER'S MAIDEN NAME Nellie Griswold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 1946 to 1951		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address (Wife) Shirley F. Jarvis (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Osteogenic Sarcoma (humerus fin) 196X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH 6 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8 June , 19 56 , to 14 Dec. , 19 56 , that I last saw the deceased alive on 14 Dec. , 19 56 , and that death occurred at 2:00 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED W.H. Druckemiller M.D. U.S. Naval Hospital, Bethesda, Md. 12-15-56							
ACTUAL SIGNATURE W.H. Druckemiller M.D. U.S. Naval Hospital, Bethesda, Md. 12-15-56							
PHYSICIAN'S NAME (Type) W.H. Druckemiller, CAPT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-18-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 12-15-56	
				24b. REGISTRAR'S SIGNATURE Ray E. Russell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU A. S.

DEC 19 1956

RECEIVED

12672 CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sugarland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sugarland, Dawsonville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dawsonville, RD #				d. STREET ADDRESS Dawsonville, Md			
3. NAME OF DECEASED (Type or print) First JOHN Middle HENRY Last JOHNSON				4. DATE OF DEATH Month Dec. Day 13, Year 19 56			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1865		9. AGE (In years last birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Johnson				14. MOTHER'S MAIDEN NAME Margaret Diggs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 11 yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT William Johnson		Address Dawsonville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) 10 years.						INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rt. hemiparesis,						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 December, 1956 , to 13 Dec, 1956 , that I last saw the deceased alive on 13 December, 1956 , and that death occurred at 11 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon M. Smith				ADDRESS (Street, city or town, state) Barnesville, Md 15006			
PHYSICIAN'S NAME (Type) Gordon M. Smith				DATE SIGNED DEC 19 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 12/16/56		22c. NAME OF CEMETERY OR CREMATORY St. Paul,		22d. LOCATION (City, town, or county) (State) Sugarland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Sander				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DEC 19 1956	
				24b. REGISTRAR'S SIGNATURE Charles Elgin			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

1000

BUREAU V. 5

DEC 20 1956

RECEIVED

12673 CERTIFICATE OF DEATH

Reg. Dist. No.

126354

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>602 DEERFIELD STREET</u>		d. STREET ADDRESS <u>602 DEERFIELD STREET</u>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>AGNES</u> Last <u>JONES</u>		4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>9</u> Year <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 16, 1881</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>HARRISON</u>		14. MOTHER'S MAIDEN NAME <u>LATCHFORD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr. Clarence Jones Laurel, Md.</u> Address <u>899 4th St.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 30</u> , 19 <u>56</u> , to <u>Dec. 9</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 8</u> , 19 <u>56</u> , and that death occurred at <u>9:00</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Roberts</u> M.D. <u>8907 GEO. AVE. SILVER SPRING, MD.</u>		DATE SIGNED <u>DEC. 9, 1956</u>	
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Nov 11-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery Laurel, Prince Geo - Md.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Arnold</u> ADDRESS <u>Laurel, Md.</u>		24. REC'D BY REGISTRAR DATE <u>12/14/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Frankus Colter</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in only event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12636

12674

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	c. LENGTH OF STAY IN 1b 23 YRS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9216 COLUMBIA BLVD.		d. STREET ADDRESS 9216 COLUMBIA BLVD.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LOTTIE Middle Gertrude Last JONES		4. DATE OF DEATH Month December Day 27 Year 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 14, 1865
9. AGE (In years last birthday) 91		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) ALEXANDRIA, VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME IGNATIUS FORD	
14. MOTHER'S MAIDEN NAME CHARLOTTE G. Simpson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Fannie G. Kellum, 9216 Columbia Blvd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accidents 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH 6 days years years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June, 1948 to Dec. 27, 1956 that I last saw the deceased alive on Dec 26, 1956 , and that death occurred at 1:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John S. Rogers		M.D. 1919 - January 10, 1927 - 56	
PHYSICIAN'S NAME (Type) JOHN S. ROGERS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/31/56	
22c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE 12/31/56		24b. REGISTRAR'S SIGNATURE Francis Potter	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12637

12675

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address), OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>139 Ritchie Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>Sinton</u> First <u>Jordan</u> Middle <u>Jordan</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-15-12</u>	
9. AGE (In years lost birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mississippi</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>William Jordan</u>				14. MOTHER'S MAIDEN NAME <u>Flay V. Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>See A Jordan (brother)</u> Address <u>Takoma Park, 28 Ritchie Ave. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL HEMORRHAGE, MASSIVE</u> DUE TO (c) <u>CEREBRAL ARTERIOSCLEROSIS, HYPERTENSIVE HEART DISEASE UNKNOWN</u>						INTERVAL BETWEEN ONSET AND DEATH <u>MINUTES</u> <u>3 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 26</u> , 19 <u>56</u> , to <u>Dec 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 28</u> , 19 <u>56</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>837 Georgia Ave - Silver Spring, Md</u> DATE SIGNED <u>12/29-56</u>							
ACTUAL SIGNATURE <u>Arvin H. Traen</u>		M.D. <u> </u>					
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Surden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>	

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 3 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12676

CERTIFICATE OF DEATH

12638

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookmont</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>6100 Ridge Drive</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>W.</u> Last <u>King</u>				4. DATE OF DEATH Month <u>12</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-7-89</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock Tender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Wright</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Leslie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Thomas (son)</u> Address <u>6100 Ridge Drive Brookmont</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertension - Arteriosclerotic Heart Disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u> <u>15 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October</u> , 19 <u>50</u> , to <u>December 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 26</u> , 19 <u>56</u> , and that death occurred at <u>4:19</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert G. Angle M.D.</u>				ADDRESS (Street, city or town, state) <u>5009 DelRay Ave, Bethesda Md</u> DATE SIGNED <u>12/26/56</u>			
PHYSICIAN'S NAME (Type) <u>Robert G. Angle, M.D.</u>				5009 DelRay Ave. Bethesda, Md. 12/26/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/28/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Walkers Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 12-29-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

510

BUREAU V. S.

RECEIVED

1951 3 14 v.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12610

CERTIFICATE OF DEATH

Reg. Dist. No.

12639
223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 22 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
		d. STREET ADDRESS 9 Brooks Ave.	
3. NAME OF DECEASED (Type or print) First Allie Middle Hunter Last Kirkman		4. DATE OF DEATH Month December Day 30 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-20-73
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Clark Gwinn		14. MOTHER'S MAIDEN NAME Frances Hill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) Arteriosclerosis + Gangrene (Toes)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/7/56 , to 12/30/56 , that I last saw the deceased alive on 12/29/56 , and that death occurred at 5:50 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert A. Hare		ADDRESS (Street, city or town, state) Takoma Park, Md.	
PHYSICIAN'S NAME (Type) Robert A. Hare		DATE SIGNED 12/30/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-1-57	
22c. NAME OF CEMETERY OR CREMATORY Forest Hill		22d. LOCATION (City, town, or county) (State) Gaithersburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. E. Dantner		ADDRESS Gaithersburg Md.	
24a. REG'D BY REGISTRAR JAN 2 1957		24b. REGISTRAR'S SIGNATURE J. Wilson Dodd	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

JAN 4 1957

RECEIVED

12611

CERTIFICATE OF DEATH

12640

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 Mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. + Hosp.</u>				d. STREET ADDRESS <u>11700 Idlewood Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Alice Marie Kittredge</u>				4. DATE OF DEATH <u>Dec. 29 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-4-00</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD., BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. R. Greshette</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Blake</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give year or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>FRED G. KITTEDGE</u> Address <u>SILVER SPRING MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>572.1 Abscess Sigmoid Area</u> DUE TO (b) <u>Ruptured Sigmoid Diverticulum</u> DUE TO (c) <u>Chr. Sigmoid Diverticulitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 mo.</u> <u>2 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Malnutrition</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Oct. 16 1956</u> , to <u>Dec. 29 1956</u> , that I last saw the deceased alive on <u>Dec. 28 1956</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul T. Starr</u> M.D.				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave. 12-29-56</u>			
PHYSICIAN'S NAME (Type) <u>PAUL V. STARR</u>				DATE SIGNED <u>Jakoma Park, Md.</u>			
22a. BURIAL, CREMATION, or other (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>12/31/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND & GOSL. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers</u>				ADDRESS <u>5801 Cleveland Ave. Balt. 7 Md</u>		24a. REC'D BY REGISTRAR <u>12 3 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. H. H. H. H.</u>			

MEDICAL CERTIFICATION

2

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17

75

DP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG209 1-4-57 et

12641

12677

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE New York b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN 1b 4-22-56-12-8-56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS SANITARIUM				d. STREET ADDRESS 146-22 - 230th Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ANNA First Middle Last KRAMER				4. DATE OF DEATH Month 12 Day 8 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1890 3-15-1890	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 8 Days 23 Hours Min. 		IF UNDER 24 HRS. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Austria	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Jack Kramer - Same as Item #2 Address	
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis heart disease DUE TO (c) Hypertension				INTERVAL BETWEEN ONSET AND DEATH 10 minutes years years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cholelithiasis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May , 1952 to 12/8 , 1956 that I last saw the deceased alive on 12/7 , 1956 and that death occurred at 12 PM from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 12600 Parkland Drive DATE SIGNED 12/8/56			
ACTUAL SIGNATURE Charles M. Weber M.D.							
PHYSICIAN'S NAME (Type) Charles M. Weber				Rockville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 12/8/1956		22c. NAME OF CEMETERY OR CREMATORY Montefiore		22d. LOCATION (City, town, or county) (State) Queens Co. New York	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md. ADDRESS				24a. REC'D BY REGISTRAR 12-11-56		24b. REGISTRAR'S SIGNATURE Bessie M. Rosen	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 CERTIFICATE OF DEATH

NAME OF DECEASED ROBERT A. CAMPBELL - 7824 W. Ave. Baltimore, Md.		SEX Male	
DATE OF BIRTH 12/10/1898		AGE 57 years	
PLACE OF BIRTH Baltimore, Maryland		OCCUPATION Clerk	
RESIDENCE 7824 W. Ave. Baltimore, Md.		CAUSE OF DEATH Myocardial Infarction	
DATE OF DEATH 12/13/1956		TIME OF DEATH 10:30 AM	
PLACE OF DEATH Home		SIGNATURE OF PHYSICIAN [Signature]	
SIGNATURE OF DECEASED [Signature]		SIGNATURE OF WITNESS [Signature]	
SIGNATURE OF NEXT OF KIN [Signature]		SIGNATURE OF BURIAL OFFICIAL [Signature]	
SIGNATURE OF REGISTRAR [Signature]		SIGNATURE OF CLERK [Signature]	

BUREAU V. 2

DEC 13 1956

RECEIVED

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. SIGNATURE OF PHYSICIAN [Illegible]	
10. SIGNATURE OF REGISTRAR [Illegible]		11. SIGNATURE OF WITNESS [Illegible]		12. SIGNATURE OF DECEASED [Illegible]	
13. SIGNATURE OF DECEASED [Illegible]		14. SIGNATURE OF DECEASED [Illegible]		15. SIGNATURE OF DECEASED [Illegible]	
16. SIGNATURE OF DECEASED [Illegible]		17. SIGNATURE OF DECEASED [Illegible]		18. SIGNATURE OF DECEASED [Illegible]	
19. SIGNATURE OF DECEASED [Illegible]		20. SIGNATURE OF DECEASED [Illegible]		21. SIGNATURE OF DECEASED [Illegible]	
22. SIGNATURE OF DECEASED [Illegible]		23. SIGNATURE OF DECEASED [Illegible]		24. SIGNATURE OF DECEASED [Illegible]	
25. SIGNATURE OF DECEASED [Illegible]		26. SIGNATURE OF DECEASED [Illegible]		27. SIGNATURE OF DECEASED [Illegible]	
28. SIGNATURE OF DECEASED [Illegible]		29. SIGNATURE OF DECEASED [Illegible]		30. SIGNATURE OF DECEASED [Illegible]	
31. SIGNATURE OF DECEASED [Illegible]		32. SIGNATURE OF DECEASED [Illegible]		33. SIGNATURE OF DECEASED [Illegible]	
34. SIGNATURE OF DECEASED [Illegible]		35. SIGNATURE OF DECEASED [Illegible]		36. SIGNATURE OF DECEASED [Illegible]	
37. SIGNATURE OF DECEASED [Illegible]		38. SIGNATURE OF DECEASED [Illegible]		39. SIGNATURE OF DECEASED [Illegible]	
40. SIGNATURE OF DECEASED [Illegible]		41. SIGNATURE OF DECEASED [Illegible]		42. SIGNATURE OF DECEASED [Illegible]	
43. SIGNATURE OF DECEASED [Illegible]		44. SIGNATURE OF DECEASED [Illegible]		45. SIGNATURE OF DECEASED [Illegible]	
46. SIGNATURE OF DECEASED [Illegible]		47. SIGNATURE OF DECEASED [Illegible]		48. SIGNATURE OF DECEASED [Illegible]	
49. SIGNATURE OF DECEASED [Illegible]		50. SIGNATURE OF DECEASED [Illegible]		51. SIGNATURE OF DECEASED [Illegible]	
52. SIGNATURE OF DECEASED [Illegible]		53. SIGNATURE OF DECEASED [Illegible]		54. SIGNATURE OF DECEASED [Illegible]	
55. SIGNATURE OF DECEASED [Illegible]		56. SIGNATURE OF DECEASED [Illegible]		57. SIGNATURE OF DECEASED [Illegible]	
58. SIGNATURE OF DECEASED [Illegible]		59. SIGNATURE OF DECEASED [Illegible]		60. SIGNATURE OF DECEASED [Illegible]	
61. SIGNATURE OF DECEASED [Illegible]		62. SIGNATURE OF DECEASED [Illegible]		63. SIGNATURE OF DECEASED [Illegible]	
64. SIGNATURE OF DECEASED [Illegible]		65. SIGNATURE OF DECEASED [Illegible]		66. SIGNATURE OF DECEASED [Illegible]	
67. SIGNATURE OF DECEASED [Illegible]		68. SIGNATURE OF DECEASED [Illegible]		69. SIGNATURE OF DECEASED [Illegible]	
70. SIGNATURE OF DECEASED [Illegible]		71. SIGNATURE OF DECEASED [Illegible]		72. SIGNATURE OF DECEASED [Illegible]	
73. SIGNATURE OF DECEASED [Illegible]		74. SIGNATURE OF DECEASED [Illegible]		75. SIGNATURE OF DECEASED [Illegible]	
76. SIGNATURE OF DECEASED [Illegible]		77. SIGNATURE OF DECEASED [Illegible]		78. SIGNATURE OF DECEASED [Illegible]	
79. SIGNATURE OF DECEASED [Illegible]		80. SIGNATURE OF DECEASED [Illegible]		81. SIGNATURE OF DECEASED [Illegible]	
82. SIGNATURE OF DECEASED [Illegible]		83. SIGNATURE OF DECEASED [Illegible]		84. SIGNATURE OF DECEASED [Illegible]	
85. SIGNATURE OF DECEASED [Illegible]		86. SIGNATURE OF DECEASED [Illegible]		87. SIGNATURE OF DECEASED [Illegible]	
88. SIGNATURE OF DECEASED [Illegible]		89. SIGNATURE OF DECEASED [Illegible]		90. SIGNATURE OF DECEASED [Illegible]	
91. SIGNATURE OF DECEASED [Illegible]		92. SIGNATURE OF DECEASED [Illegible]		93. SIGNATURE OF DECEASED [Illegible]	
94. SIGNATURE OF DECEASED [Illegible]		95. SIGNATURE OF DECEASED [Illegible]		96. SIGNATURE OF DECEASED [Illegible]	
97. SIGNATURE OF DECEASED [Illegible]		98. SIGNATURE OF DECEASED [Illegible]		99. SIGNATURE OF DECEASED [Illegible]	
100. SIGNATURE OF DECEASED [Illegible]		101. SIGNATURE OF DECEASED [Illegible]		102. SIGNATURE OF DECEASED [Illegible]	

RECEIVED
DEC 7 1956
BUREAU V. 3

12679

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 56</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10,105 McKENNY AVENUE</u>				d. STREET ADDRESS <u>10105 McKenny Ave</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Beauford Langford</u>				4. DATE OF DEATH Month Day Year <u>December 17 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1892</u>	9. AGE (In years last birthday) <u>64</u> yn.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done if deceased was working life, even if retired) <u>Wholesale Salesman Administrator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>L.C. Smith Typewriter Co. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>	
13. FATHER'S NAME <u>Sydney W. Langford</u>				14. MOTHER'S MAIDEN NAME <u>McLAIN Mary James</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>253-03-4721</u>		17. INFORMANT Address <u>Gertrude Fune Langford</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1952, to _____, 1956, that I last saw the deceased alive on <u>November 29, 1956</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Edward J. Richards</u> M.D. <u>10110 Georgia Ave</u> <u>12-17-56</u> PHYSICIAN'S NAME (Type) <u>Edward J. Richards</u> <u>Silver Spring Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Werner E. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>12/20/56</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES M. JONES		45		M		W		1910		BALTIMORE		BALTIMORE		MARYLAND	
MANNER OF DEATH		CAUSE OF DEATH		DISEASE		SYMPTOMS		TREATMENT		HISTORY		PREVIOUS ILLNESS		PREVIOUS SURGERY	
NATURAL		HEART DISEASE		CORONARY ARTERY DISEASE		ANGINA PECTORIS		HYPERTENSION		DIABETES		ASTHMA		GOUT	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		CITY OF BURIAL		COUNTRY OF BURIAL	
1956		BALTIMORE		BALTIMORE		BALTIMORE		1956		BALTIMORE		BALTIMORE		BALTIMORE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF MINISTER OF THE GOSPEL		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES		J. M. JONES	

BUREAU V. S.

DEC 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12680

CERTIFICATE OF DEATH

Reg. Dist. No.

12644

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suburban Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Heatherburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>Rt. 3</u>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Edmonia</u> Last <u>Lee</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29 1893</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11c. BIRTHPLACE (State or foreign country) <u>Maryland</u>		11d. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Hallman Swales</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Sarah L. Lee</u>		Address <u>Wash. D.C. N.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive heart disease with</u> DUE TO (c) <u>cardiac enlargement</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>at least</u> <u>2 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 28</u> , 19 <u>56</u> , to <u>Dec 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 2</u> , 19 <u>56</u> , and that death occurred at <u>4:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Caron H. Trau</u>		ADDRESS (Street, city or town, state) <u>837 Georgia Ave - Silver Spring, Md</u>	
DATE SIGNED <u>12/3-56</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/7/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion,</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Zion, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert J. Anawden</u>		ADDRESS <u>Rock Md</u>	
24a. REC'D BY REGISTRAR <u>12-6-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

BUREAU V. S.

DEC 7 1956

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12681

CERTIFICATE OF DEATH

Reg. Dist. No.

12645

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kansas b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.			c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Norton 54X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 708 North Second Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alan Middle Dean Last Lesh		4. DATE OF DEATH Month December Day 7 Year 1956					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 5, 1950		9. AGE (In years lost birthday) 6 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Phillip A. Lesh				14. MOTHER'S MAIDEN NAME Isabel Carmen Wiltrout			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Cerebral seizures Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral seizures DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 3, 1956 to December 7, 1956 , that I last saw the deceased alive on December 7, 1956 , and that death occurred at 9 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert Gordon Long		M.D. The Clinical Center		ADDRESS (Street, city or town, state)		DATE SIGNED 12-8-56	
PHYSICIAN'S NAME (Type) Robert Gordon Long, M. D.				National Institutes of Health		Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) 12/9/56		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Norton, Kansas	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Kins Co. 2901-14th St NW				ADDRESS WASH. D. C.		24a. REC'D BY REGISTRAR DATE 12-11-56	
				24b. REGISTRAR'S SIGNATURE Yessie M. Thompson			

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 FilmG210 1-30-57 et

12682

CERTIFICATE OF DEATH

Reg. Dist. No. 2/2

12646

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville--Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Oscar Middle Ira Last Lessig				4. DATE OF DEATH Month Dec Day 16 Year 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 6 1905		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Engineer, U.S. Gov.				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Oscar Lessig				14. MOTHER'S MAIDEN NAME Lena Von Zehrold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Oscar Lessig, Poolesville, R.F.D. Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Colon (operated) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 days (st) 1 1/2 years							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 Dec , 19 56 , to 16 Dec , 19 56 , that I last saw the deceased alive on 15 Dec , 19 56 , and that death occurred at 2:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon M. Smith				ADDRESS (Street, city or town, state) Barnesville, Md			
PHYSICIAN'S NAME (Type) Gordon M. Smith, M.D.				DATE SIGNED 16 Dec 56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/56		22c. NAME OF CEMETERY OR CREMATORY Highland Cemetery		22d. LOCATION (City, town, or county) (State) Danville, Va	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Hilton, Barnesville, Md				24a. REC'D BY REGISTRAR DATE 12/17/56		24b. REGISTRAR'S SIGNATURE Charles W. Elgin <i>per DGS</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12683

CERTIFICATE OF DEATH

12647

Reg. Dist. No. 214

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON	c. LENGTH OF STAY IN 1b 4 months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS REST HOME		d. STREET ADDRESS 3308 HARRELL STREET	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle CATHERINE Last LINKINS		4. DATE OF DEATH Month DECEMBER Day 12 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 28, 1871
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ALFRED LINKINS	
14. MOTHER'S MAIDEN NAME LUCY DWYER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Ada L. SINYARD, 11,501 Newport Mills, Wheaton, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443 X IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 hours 15 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 51 , to December 12 , 19 56 , that I last saw the deceased alive on December 6 , 19 56 , and that death occurred at 2:45 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring, Maryland DATE SIGNED ACTUAL SIGNATURE A. D. Bonifant M.D. PHYSICIAN'S NAME (Type) A. D. Bonifant, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/14/56	
22c. NAME OF CEMETERY OR CREMATORY ROCKVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey		24a. REC'D BY REGISTRAR DATE 12/17/56	
24b. REGISTRAR'S SIGNATURE James Potter			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE DATE		8. OCCUPATION		9. CAUSE OF DEATH		10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12684

CERTIFICATE OF DEATH

Reg. Dist. No. 215

12648

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 52 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 1015 Busac Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Linda Middle Louise Last LLOYD		4. DATE OF DEATH Month Dec. Day 2 Year 19 56	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 Oct. 1956
9. AGE (In years last birthday) 1 yrs. 29 Months 1 Days 29 Hours Min.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Theodore L. LLOYD, Jr.		14. MOTHER'S MAIDEN NAME Mary Louise MC MANUS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Official Navy Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 340.9 IMMEDIATE CAUSE (a) Pachymeningitis, hemorrhagica, externa DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2 mo DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) internal hydrocephalus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 Oct. , 19 56 , to 2 Dec. , 19 56 , that I last saw the deceased alive on 2 Dec. , 19 56 , and that death occurred at 12:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 12-3-56			
ACTUAL SIGNATURE Howard A. Pearson M.D.		U.S. Naval Hospital, Bethesda, Md.	
PHYSICIAN'S NAME (Type) Howard A. Pearson, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-7-56	
22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Jacksonville, Florida	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		24a. REC'D BY REGISTRAR 12-3-56	
24b. REGISTRAR'S SIGNATURE Myrtle Carrelly			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 SILVER SPRING		c. LENGTH OF STAY IN 1b 15 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9904 CAPITAL VIEW AVENUE				d. STREET ADDRESS 9904 CAPITAL VIEW AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MINNIE Middle ELIZABETH Last LOCKHART				4. DATE OF DEATH Month DEC. Day 5 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 27, 1880	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PHINEAS ORNDORFF				14. MOTHER'S MAIDEN NAME MARY ANN LINABERG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Charles R. Cleaves, 9904 Capital View Ave. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420x Coronary occlusion DUE TO (b) sudden Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/8/56		22c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S CEMETERY		22d. LOCATION (City, town, or county) (State) MT. WILLIAMS, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MARYLAND				24a. REC'D BY REGISTRAR DATE 12/6/56		24b. REGISTRAR'S SIGNATURE Francis J. Miller	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEC 10 1956

RECEIVED

12686

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3806 Baltimore Ave.		d. STREET ADDRESS 3806 Baltimore Ave.	
3. NAME OF DECEASED (Type or print) ALBERT LAFAYETTE LOHM		4. DATE OF DEATH December 24, 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1884
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR 7 Months 13 Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Lawyer-Self Emp. W. Virginia	
11. BIRTHPLACE (State or foreign country) US		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George W. Lohm		14. MOTHER'S MAIDEN NAME Rose Shaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Genevieve H. Lohm-Item#2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, 420.1 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO 4 months (c) Generalized Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Essential Hypertension		INTERVAL BETWEEN ONSET AND DEATH 4 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1956 , to Dec 24, 1956 , that I last saw the deceased alive on Dec 24, 1956 , and that death occurred at 10:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave Edgewood, Md DATE SIGNED 12/24/56			
ACTUAL SIGNATURE John J. Curry M.D.			
PHYSICIAN'S NAME (Type) John J. Curry			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 12/26/56	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	22d. LOCATION (City, town, or county) (State) Suitland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE - 27-56	24b. REGISTRAR'S SIGNATURE Bernice M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED
JAN 13 1966

John A. Clark

Cedar Hill Cemetery

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1954-21 101 MAY 15 '54

12612

CERTIFICATE OF DEATH

126513

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hospital</u>				d. STREET ADDRESS <u>4731 - 30th St N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>FRANCIS</u> First <u>Sales</u> Middle <u>Machen</u> Last				4. DATE OF DEATH <u>12</u> Month <u>25</u> Day <u>1956</u> Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-18-73</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor - Physician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Wm. H. Machen</u>				14. MOTHER'S MAIDEN NAME <u>Mary ANN SHORT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT <u>Wash. San + Hosp Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>199.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Cardiac Failure</u> DUE TO (c) <u>Terminal</u>						INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6/3/1956</u> to <u>12/25/1956</u> that I last saw the deceased alive on <u>12/25/1956</u> , and that death occurred at <u>12:50 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare</u> M.D.				ADDRESS (Street, city or town, state) <u>Takoma Park, Md.</u>			
DATE SIGNED <u>12/25/56</u>							
PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>				ADDRESS <u>Takoma Park, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/28/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hiner Co. - 2901 14th St. N.W.</u>				ADDRESS <u>Washington, D. C.</u>		24a. REC'D BY REGISTRAR <u>DEC 27 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>J. H. H. H. H.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 27 1956

RECEIVED

12613

CERTIFICATE OF DEATH

12652

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
c. LENGTH OF STAY IN 1b <u>11 mo.</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8500 Flower Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				e. STREET ADDRESS <u>8318 Haddon Drive</u>			
3. NAME OF DECEASED (Type or print) <u>MacHadden Mary MacKnight</u>				4. DATE OF DEATH <u>Dec 5 1956</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 26, 1870</u>	
9. AGE (In years last birthday) <u>86</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>London, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Unknown to me</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Sanitarium Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, Generalized</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>July 1, 1956</u> , to <u>Dec 5, 1956</u> , that I last saw the deceased alive on <u>Dec 3, 1956</u> , and that death occurred at <u>7:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Whitlock</u> M.D.				ADDRESS (Street, city or town, state) <u>7701 Carroll Ave</u>			
DATE SIGNED <u>12-5-56</u>				DATE SIGNED <u>12-5-56</u>			
PHYSICIAN'S NAME (Type) <u>J. M. Whitlock, M.D.</u>				ADDRESS <u>Takoma Park, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>Aug. 6, 1956</u>		<u>Cedar Hill Crematory</u>		<u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				ADDRESS <u>254 Carroll Ave</u>			
DATE <u>12/6/56</u>				24a. REC'D BY REGISTRAR <u>J. Arthur Walters</u>			
24b. REGISTRAR'S SIGNATURE				DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12687

CERTIFICATE OF DEATH

12653

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, MD.</u>	c. LENGTH OF STAY IN 1b <u>3 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8820 Sundale Dr.</u>		d. STREET ADDRESS <u>8820 Sundale Dr.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MAX</u> Middle <u>MALAMUT</u> Last <u>MALAMUT</u>		4. DATE OF DEATH <u>12/30/56</u> Month <u>12</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 22, 1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	11. BIRTHPLACE (State or foreign country) <u>Russia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Isaac Malamut</u>	
14. MOTHER'S MAIDEN NAME <u>Toba (Unknown)</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>150 22 5664</u>		17. INFORMANT <u>Silverspring Address. Paul Malamut 8820 Sundale Dr.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MAIGNANCY OF LUNG (TYPE UNDETERMINED)</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIO SCLEROTIC LARGE VASCULAR DISEASE</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>56</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/31</u> , 19 <u>56</u> , to <u>12/30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/29</u> , 19 <u>56</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George P. George</u>		ADDRESS (Street, city or town, state) <u>9404 Colverville Rd, Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George P. George</u>		DATE SIGNED <u>12/30/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/31/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rosenbain Jewish</u>	22d. LOCATION (City, town, or county) (State) <u>Rosenbain, Cumb. N.J.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. H. H.</u>		24a. REC'D BY REGISTRAR <u>1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Lawrence P. H.</u>		24c. DATE <u>1957</u>	

12688 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Montgomery		MARYLAND		STATE Maryland		COUNTY Montgomery	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 56 Silver Spring		LENGTH OF STAY (in this place) 4 1/2 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chevy Chase 15			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Marilea Nursing Home 14511 Colesville Road		STREET ADDRESS (If rural give location) 6124 Western Avenue					
3. NAME OF DECEASED: (First) (Middle) (Last) John C. F. McCLELLAN				4. DATE (Month) (Day) (Year) OF DEATH: Dec. 25 19 56			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: Nov. 16, 1862	9. AGE last birthday 94 yrs.	IF UNDER 1 YEAR Months 1 Days 9 Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter		10B. KIND OF BUSINESS OR INDUSTRY: Self-employed		11. BIRTHPLACE (State or foreign country): Xenia, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: David McClellan				14. MOTHER'S MAIDEN NAME: Melvina Cooper			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) None		17. INFORMANT & ADDRESS: Mrs. Stanley E. Fisher-Same Item #2			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) acute myocardial disease						5 min	
ANTECEDENT CAUSE (S) DUE TO (B) chronic myocardial disease						years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) generalized arteriosclerosis						years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. None							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4-20, 1955 to 12-25, 1956 , that I last saw the deceased alive on 12-17, 1956 , and that death occurred at 7 P. M, from the causes and on the date stated above.							
SIGNATURE John D. Regan				ADDRESS 1919 Seminary Rd. Spring 12-25-56		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial-transit		DATE THEREOF 12/26/56		NAME OF CEMETERY OR CREMATORY Woodland		LOCATION (City, town, or county) (State) Green Co. Ohio	
DATE REC'D BY LOCAL REGISTRAR 12-27-56		REGISTRAR'S SIGNATURE James Potter		24. FUNERAL DIRECTOR Robert A. Pumphrey-7557 Wisconsin Ave. Bethesda 14, Md.			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 55

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 31 1956
BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12655

Reg. Dist. No.

214

12689

Item 9 Film G210 1-20-57

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton			c. LENGTH OF STAY IN 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville RFD #2			d. STREET ADDRESS Norbeck
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Bladensburg Rd. & Georgia Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First August Middle McKelvin Last McKelvin				4. DATE OF DEATH Month 12 Day 10 Year 56			
5. SEX male	6. COLOR OR RACE ool.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 16, 1888		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 68 Days 19	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew Mc Kelvin				14. MOTHER'S MAIDEN NAME Frances Miles			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. McKelvin Address Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause lost.							INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Died while passenger on bus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 12/14/56	22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant,		22d. LOCATION (City, town, or county) (State) Norbeck, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Robert R. Snowden				ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DEC 19 1956	
				24b. REGISTRAR'S SIGNATURE Frances Patten			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose in this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEC 20 1956

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 13, 14 Film G209 1-4-57 et

12657

12628 CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		LENGTH OF STAY (in this place) <u>1 1/2 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		TOWN <u>56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Waverley</u>				STREET ADDRESS (If rural give location) <u>2002 - Osborne Drive</u>			
3. NAME OF DECEASED (Type or Print) <u>Mary</u> (First) (Middle) (Last) <u>Meenehan</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec 19 1956</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 18, 1872</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Mrs. A. Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Wash. D.C. Mrs. Alice Ruane - 4331 - Alhambra</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
260X IMMEDIATE CAUSE (A) <u>Acute Congestive Heart Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Sclerosis - Hypertension</u>				DUE TO (C) <u>Diabetes Mellitus</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION <u>None</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>None</u>			
22. I hereby certify that I attended the deceased from <u>Dec. 19, 1956</u> , to <u>Dec. 19, 1956</u> , that I last saw the deceased alive on <u>Dec. 19, 1956</u> , and that death occurred at <u>11:35 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James M. Loftus</u>		DATE THEREOF <u>12/22/56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) <u>Suitland, Md.</u>	
23. BURIAL, CREMATION REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>12/22/56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) <u>Suitland, Md.</u>	
24. REC'D BY REGISTRAR <u>DEC 26 1956</u>		REGISTRAR'S SIGNATURE <u>Lewell Kogb...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>	

DATE SIGNED

(State)

CERTIFICATE OF DEATH

STATE OF NEW YORK - DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

FILE NO.

NAME OF DECEASED

PLACE OF BIRTH

DATE OF BIRTH
PLACE OF BIRTH

DATE OF DEATH
PLACE OF DEATH

STATE OF NEW YORK

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
This certificate is to be filled out by the attending physician or the coroner, and is to be filed in the office of the Registrar of Vital Statistics, who will issue a copy of the same to the family of the deceased.

BUREAU V. 8

DEC 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12658

Item 9, Film G208, 12/12/56 fcy CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN 1b 18 days		d. STREET ADDRESS 4000 Cathedral Ave., N.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ellis Middle Bell Last MILLER		4. DATE OF DEATH Month December Day 8 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Dec. 1879
9. AGE (In years last birthday) 76 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Marine Corps		10b. KIND OF BUSINESS OR INDUSTRY USMC (Retired)	
11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Hiram C. Miller		14. MOTHER'S MAIDEN NAME Annie Downend	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1900 to 1936 Unknown	
17. INFORMANT (Wife) Mrs. Wilhelmina Miller (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 months.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 Nov. , 1956, to 8 Dec. , 1956, that I last saw the deceased alive on 8 DEC. , 1956, and that death occurred at 6:05 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE B. L. Canaga, Jr. M.D. U.S. Naval Hospital, Bethesda, Md., 12-8-56 PHYSICIAN'S NAME (Type) B. L. CANAGA, JR. CAPT, MC, USN U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-11-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's & Sons Joseph Gawler's & Sons, 1756 Penn Ave., N.W.		24a. REC'D BY REGISTRAR DATE 12-8-56	
24b. REGISTRAR'S SIGNATURE Mary E. Parrelly			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

RECEIVED

DEC 10 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12659

12691

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN TB <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Ednor</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS <u>Rt. #3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Thomas</u> Last <u>Money</u>				4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/8/04</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Washington D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Effie Bontz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u> </u>		17. INFORMANT <u>Hospital Record</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarction of brain (infarction)</u> DUE TO <u>T thrombosis ant. cerebral artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				21. I certify that I attended the deceased from <u>12/2</u> , 19 <u>56</u> , to <u>12/29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/29</u> 19 <u>56</u> , and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u> DATE SIGNED <u>12/29/56</u>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u> </u>				PHYSICIAN'S NAME (Type) <u>C. H. Ligon, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>				22b. DATE THEREOF <u>1/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Washington, D.C.</u> (State) <u> </u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Washington D.C.</u>			
24a. REC'D BY REGISTRAR <u> </u> DATE <u> </u>				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

JAN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12692

CERTIFICATE OF DEATH

12660

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>24 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>7829 Old Chester Road</u>			
3. NAME OF DECEASED (Type or print) <u>WINNYRED</u> First Middle Last <u>MORAN</u>				4. DATE OF DEATH Month <u>12</u> - Day <u>18</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-4-83</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Thomas MORAN</u>				14. MOTHER'S MAIDEN NAME <u>ANN BERGIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Helen Arsen (sister)</u> Address <u>Bethesda, Md. 7829 Old Chester Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.1</u> DUE TO <u>MASSIVE GASTRO-INTESTINAL HEMORRHAGE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ESOPHAGEAL VARICES</u> DUE TO (c) <u>LAENNEC'S CIRRHOSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 HOURS</u> <u>UNKNOWN</u> <u>UNKNOWN</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12/16</u> , 19 <u>56</u> , to <u>12/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/17</u> , 19 <u>56</u> , and that death occurred at <u>9:40 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. L. Marks</u>				M.D. <u>6306 Wisconsin Ave</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>12/18/56</u>			
PHYSICIAN'S NAME (Type) <u>I. L. MARKS, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial-Transit</u>		<u>12/18/56</u>		<u>Most Holy Redeemer</u>		<u>Schenectady, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>DATE 12-28-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

Reg. No. 10

1. Name of Deceased: *John Doe*
2. Sex: *Male*
3. Age: *45*
4. Date of Birth: *1910*
5. Date of Death: *1956*
6. Place of Death: *Home*
7. Cause of Death: *Heart Disease*
8. Physician: *Dr. Smith*
9. Burial Place: *Cemetery*
10. Signature of Physician: *[Signature]*
11. Signature of Registrar: *[Signature]*

RECEIVED
DEC 1956
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE, 18

12693

CERTIFICATE OF DEATH

12661

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2hr.45 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 4024 Washington Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last MORRIS				4. DATE OF DEATH Month December Day 24 Year 19 56			
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-24-56	
9. AGE (In years last birthday) 2		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Charles L. Morris		14. MOTHER'S MAIDEN NAME Valla Clements			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Mother) Valla L. Morris (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IMMATUREITY & PREMATUREITY 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PREMATURE LABOR (30 WEEKS GESTATION) DUE TO (c) 2hr 45 min PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 24 Dec. , 19 56 , to 24 Dec. , 19 56 , that I last saw the deceased alive on 24 Dec. , 19 56 , and that death occurred at 12:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Paul P. McBride M.D. U.S. Naval Hospital, Bethesda, Md. 12-26-56 PHYSICIAN'S NAME (Type) PAUL P. MC BRIDE, LT MC USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 28 Dec. 1956		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 12-26-56		24b. REGISTRAR'S SIGNATURE Mary E. Russell	

2051286XV6

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
CHARLES H. WATTS		Male		35		12-24-23		Maryland		Baltimore		Maryland		U.S.A.	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
None		None		None		12-24-23		Maryland		Baltimore		Maryland		U.S.A.	
FATHER		MOTHER		SPOUSE		CHILDREN		GRANDCHILDREN		SIBLINGS		OTHER RELATIVES		OTHER	
None		None		None		None		None		None		None		None	

RECEIVED
DEC 28 1956
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12662

Reg. Dist. No.

12679

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Randolph Road				d. STREET ADDRESS 30 Mannakee Street			
3. NAME OF DECEASED (Type or print) First CHARLES Middle E. Last MOSSBURG				4. DATE OF DEATH Month Dec. Day 7, Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 9, 1899	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 3 Days 28		IF UNDER 24 HRS. Hours 28 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor-Self Emp.		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles M. Mossburg				14. MOTHER'S MAIDEN NAME Mary A. Trail			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes-Unknown		17. INFORMANT Address Mrs Hester E. Mossburg-Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 12/7/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/10/1956		22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) _____ (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-7557 Wis. Ave. Beth. Md.				24a. REC'D BY REGISTRAR DATE 12/10/56		24b. REGISTRAR'S SIGNATURE Paula Kraft	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

REC 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12694 CERTIFICATE OF DEATH

12663

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 20 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLORENCE Middle ESTELLE Last MYERS		4. DATE OF DEATH Month 12 Day 26 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/17/91
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR: Months 6 Days 9 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) NEW YORK STATE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Hallenbeck		14. MOTHER'S MAIDEN NAME Maggie VanSchoick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT John E. Myers		Address 5 HOME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive heart disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 20 minutes several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan , 19 54 , to 12-26 , 19 56 , that I last saw the deceased alive on 12-26 , 19 56 , and that death occurred at 5:45 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8519 Hazelwood Drive, Beth., Md. DATE SIGNED _____			
ACTUAL SIGNATURE K.H. Mish		M.D. _____	
PHYSICIAN'S NAME (Type) K.H. Mish		8519 Hazelwood Drive, Beth., Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Trans		22b. DATE THEREOF 12/28/56	
22c. NAME OF CEMETERY OR CREMATORY Boonton		22d. LOCATION (City, town, or county) (State) Boonton, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Robert G. Thompson		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR DATE 12-29-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

CERTIFICATE OF DEATH

PLACE OF DEATH HOME		COUNTY BALTIMORE	
DATE OF DEATH JAN 2 1957		TIME OF DEATH 10:15 AM	
SEX MALE		AGE 78	
RACE WHITE		BIRTH DATE 1879	
BIRTH PLACE BALTIMORE, MD		BIRTH DATE 1879	
MARITAL STATUS MARRIED		OCCUPATION RETIRED	
DECEASED BY NATURAL CAUSES		CAUSE OF DEATH HEART DISEASE	
PLACE OF INTERMENT BALTIMORE		DATE OF INTERMENT JAN 2 1957	
NAME OF FUNERAL HOME ...		NAME OF MINISTER ...	
NAME OF NEXT OF KIN ...		ADDRESS OF NEXT OF KIN ...	
SIGNATURE OF DECEASED ...		SIGNATURE OF WITNESS ...	
SIGNATURE OF PHYSICIAN ...		SIGNATURE OF CORONER ...	

BUREAU V. S.

JAN 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12695

CERTIFICATE OF DEATH

12664

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 1 1/2 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		d. STREET ADDRESS 06X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Vernon Last Myers, Jr.		4. DATE OF DEATH Month December Day 12 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/11/56
9. AGE (In years last birthday) yrs. 13		IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min. 13	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME George Vernon Myers, Sr.		14. MOTHER'S MAIDEN NAME Edith Marie Gray	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Hospital Record	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hematoma and } 1 1/2 days 760.0 DUE TO Intracranial hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12/11 , 19 56 , to 12/12 , 19 56 , that I last saw the deceased alive on 12/12/56 , 19 56 , and that death occurred at 12:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Clarksville, Md. DATE SIGNED ACTUAL SIGNATURE C. S. Whitaker M.D. PHYSICIAN'S NAME (Type) C. S. Whitaker, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-14-56	
22c. NAME OF CEMETERY OR CREMATORY MAYS CHAPEL		22d. LOCATION (City, town, or county) (State) TIMONUM, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE EC. HIGGINS BATHOM, ELLICOTT CITY MD		24a. REC'D BY REGISTRAR DEC 17 1956	
24b. REGISTRAR'S SIGNATURE Latunde Lurley		25. REGISTRAR'S SIGNATURE 2073202XV7	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12696

CERTIFICATE OF DEATH

12665

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Ohio b. COUNTY Ashland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.				c. LENGTH OF STAY IN 1b 138 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1228 Cottage Street			
3. NAME OF DECEASED (Type or print) First Rose Middle Florence Last Nelson				4. DATE OF DEATH Month December Day 19 Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 17, 1905		9. AGE (In years lost birthday) yrs. 51	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Unascertainable		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Russell Gwinner			
14. MOTHER'S MAIDEN NAME Maude A. Spreng				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. Unknown				17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Peritonitis 190X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Perforation Cecum and jejunum DUE TO (c) Malignant Melanoma							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. s. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from August 3, 1956 , to December 19, 1956 , that I last saw the deceased alive on December 19, 1956 , and that death occurred at 7:15 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Arthur J. Garceau M.D.				ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 12/20/56	
PHYSICIAN'S NAME (Type) Arthur J. Garceau, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/22/56		22c. NAME OF CEMETERY OR CREMATORY Ashland		22d. LOCATION (City, town, or county) (State) Ashland, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda Md		24a. REC'D BY REGISTRAR DATE 12-22-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

RECEIVED
BUREAU V
DEC 1 1956

12614

CERTIFICATE OF DEATH

12666

Reg. Dist. No.

273

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>700 HUDSON AVE.</u>				d. STREET ADDRESS <u>1120 E Cap. St</u>			
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>L.</u> Last <u>NEWSON</u>				4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 9-1878</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Real estate</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jo B Fowler</u>				14. MOTHER'S MAIDEN NAME <u>Margaret D. Durnell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Date, no. or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Edna Facy</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral Thrombosis</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Cardio-vascular - renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>4 yrs.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>6/13/38</u> , 19____, to <u>12/7/56</u> , 19____, that I last saw the deceased alive on <u>12/7/56</u> , 19____, and that death occurred at <u>3:35</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robt. J. Bosworth</u> M.D.				ADDRESS (Street, city or town, state) <u>811-8-N.E.</u>			
DATE SIGNED _____							
PHYSICIAN'S NAME (Type) <u>ROBT J. BOSWORTH M.D.</u>				<u>Wash D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Elizabeth's</u>		22d. LOCATION (City, town, or county) <u>Wash. D.C.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lee's Sons</u> ADDRESS <u>B-3004</u>				24a. REC'D BY REGISTRAR <u>12/15/56</u> DATE		24b. REGISTRAR'S SIGNATURE <u>J. Nelson Dady</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER OF THE GOSPEL		17. SIGNATURE OF CHURCH CLERGY		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF BURIAL PLACE		20. SIGNATURE OF INTERMENT		21. SIGNATURE OF CREMATION	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

RECEIVED
DEC 12 1956
BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12667

12697

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Virginia b. COUNTY Arlington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Winchester Hospital		d. STREET ADDRESS 4647 S. 34th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First Phyllis Middle Hughes Last O'Neal		4. DATE OF DEATH Month December Day 6th , Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 17, 1914
9. AGE (In years last birthday) 42 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-typist	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesse Oakes		14. MOTHER'S MAIDEN NAME Mable Plunkett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT The Medical Record		Address Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic breast cancer to lungs and bones and probably brain DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. 11 Month Nov Day 23 Year 1956 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 23 , 19 56 , to Dec 6 , 19 56 , that I last saw the deceased alive on Dec 6 , 19 56 , and that death occurred at 11:25 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Chester Z. Haverback		ADDRESS (Street, city or town, state) National Institute of Health, Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Chester Z. Haverback		DATE SIGNED 12/6/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/8/56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Hebron		22d. LOCATION (City, town, or county) (State) Winchester, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE 12-8-56	
		24b. REGISTRAR'S SIGNATURE Bessie W. Hornspon	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Portersville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Portersville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.F.D. #1</u>				d. STREET ADDRESS <u>R.F.D. #1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dadie Linella Palmer</u>				4. DATE OF DEATH Month Day Year <u>Jan 26 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-26-88</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ind</u>		11. BIRTHPLACE (State or foreign country) <u>Ind</u>	
13. FATHER'S NAME <u>Charlie Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Peters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mary A Palmer (daughter) Home as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u> <u>6 mo?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12-26-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Warren Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Martinsburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L Shorden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 3 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Chas Ely</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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JAN 3 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG209 1-1-57 et

CERTIFICATE OF DEATH

12669

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>22 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>12807 Colesville Road</u>			
3. NAME OF DECEASED First <u>FRANCIS</u> Middle <u>XXXXXX</u> Last <u>PATTON</u>				4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-11-06</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Landscape</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Thornton Patton</u>				14. MOTHER'S MAIDEN NAME <u>Lola McKimney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>YES</u>		17. INFORMANT Address <u>Lillian (wife) 12807 Colesville Rd SS, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive retroperitoneal hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ruptured atherosclerotic abdominal aneurysm</u> DUE TO (c) <u>atherosclerosis generalized</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>			20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 18</u> , 19 <u>56</u> , to <u>Dec 19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 19</u> , 19 <u>56</u> , and that death occurred at <u>10:15</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Aaron H. Traum</u> M.D.				ADDRESS (Street, city or town, state) <u>6237 Georgia Ave Silver Spring Md</u> DATE SIGNED <u>12/19/56</u>			
PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/21/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>COLESVILLE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				24b. REC'D BY REGISTRAR <u>12-22-56</u>		24c. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		45		1-1-1920		1-15-1965		Home		Heart Disease		Natural		[Signature]		[Signature]	
11. Occupation		12. Education		13. Marital status		14. Usual residence		15. Usual place of work		16. Date of last illness		17. Date of last examination		18. Date of last treatment		19. Date of last visit		20. Date of last contact	
Teacher		High School		Married		1234 Main St		ABC Corp		1-10-1965		1-10-1965		1-10-1965		1-10-1965		1-10-1965	
21. Name of informant		22. Relationship		23. Address		24. Telephone		25. Date of interview		26. Date of completion		27. Date of filing		28. Date of review		29. Date of audit		30. Date of closure	
Jane Doe		Wife		1234 Main St		555-1234		1-15-1965		1-15-1965		1-15-1965		1-15-1965		1-15-1965		1-15-1965	

RECEIVED
JAN 14 1966
M.D. DEPARTMENT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

126303

12630

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>1 year</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>607 Blandford Avenue</u>		d. STREET ADDRESS <u>607 Blandford Avenue</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RALPH</u> Middle <u>MITCHELL</u> Last <u>PAYNE</u> 3rd.		4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1952</u>
9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ralph Mitchell Payne 2nd</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Ellis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Father (same as item 2)</u>	
17. INFORMANT <u>Father</u>		Address <u>(same as item 2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>491X ASPHYXIA</u> DUE TO <u>BRONCHOPNEUMONIA, ACUTE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Edema & Fatty metamorphosis of liver</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/22/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEORGE COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner G. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>12/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>Paul H. Kragtorp</u>	

MEDICAL CERTIFICATION

2

2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 3 1956
BUREAU Y. 4

CERTIFICATE OF DEATH

Reg. Dist. No.

217

12701

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brinklow</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brinklow</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>XXXXXXXX</u> Last <u>Peirce</u>				4. DATE OF DEATH Month <u>NOV</u> Day <u>Dec</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28, 1861</u>	9. AGE (In years last birthday) <u>95</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Peirce</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Kummer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. William Iddings Brinklow, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auxiliary Fibrillation</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/30/56</u> to <u>12/1/56</u> , that I last saw the deceased alive on <u>11/30/56</u> , and that death occurred at <u>1:00 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. H. Ligon, M.D.</u>				ADDRESS (Street, city or town, state) <u>Sandy Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>C. H. Ligon, M.D.</u>				DATE SIGNED <u>12/3/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/4/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodside Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brinklow, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W. Barber</u>				ADDRESS <u>Laytonsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>12-6-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Lawler</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

217

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Country of Birth		Usual Residence		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 15, 1910		New York		USA		New York		Heart Disease		New York		Jan 15, 1956		10:00 AM		[Signature]		[Signature]	
Occupation		Marital Status		Education		Religion		Race		Color		Height		Weight		Blood Type		Social Security No.		Maiden Name		Hospital		Physician	
Teacher		Married		High School		Catholic		White		White		5'10"		170 lbs		O+		123-45-6789		Doe		St. Mary's		Dr. Smith	
Date of Death		Time of Death		Place of Death		Cause of Death		Place of Death		Date of Death		Time of Death		Place of Death		Cause of Death		Place of Death		Date of Death		Time of Death		Place of Death	
Jan 15, 1956		10:00 AM		New York		Heart Disease		New York		Jan 15, 1956		10:00 AM		New York		Heart Disease		New York		Jan 15, 1956		10:00 AM		New York	

BUREAU V. 2

DEC 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12700 CERTIFICATE OF DEATH

Reg. Dist. No. 12671

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Fairfax</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 14, Md.</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>401 Cleveland Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Arnold</u> Middle <u>Stephen</u> Last <u>Peterson</u>				4. DATE OF DEATH Month <u>December</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10, 1950</u>		9. AGE (In years lost birthday) yrs. <u>6</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u>3</u> Min. <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Peterson</u>				14. MOTHER'S MAIDEN NAME <u>Phyllis Patton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pontine glioma</u> <u>193X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour o. p. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>November 30, 1956</u> to <u>December 8, 1956</u> , that I last saw the deceased alive on <u>December 8, 1956</u> , and that death occurred at <u>1:36 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm M. Headley</u>				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>12-8-56</u>			
PHYSICIAN'S NAME (Type) <u>William M. Headley, M. D.</u>				NATIONAL INSTITUTES OF HEALTH <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/14/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosewood</u>		22d. LOCATION (City, town, or county) (State) <u>Louisburg W. Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Taylor</u>				24a. REC'D BY REGISTRAR <u>DEC 11 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie Thompson</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]		DATE OF BIRTH [Illegible]	
PLACE OF BIRTH [Illegible]		OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]		DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF NEXT OF KIN [Illegible]	

BUREAU V. 2

DEC 11 1956

RECEIVED

12631

CERTIFICATE OF DEATH

Reg. Dist. No.

2/3

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville Pike, Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Waverly Sanitarium				d. STREET ADDRESS R.D.D #4			
3. NAME OF DECEASED (Type or print) First Helen Middle C. Last Poerstel				4. DATE OF DEATH Month Dec. Day 3 Year 1956			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/25/1901	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Waverly Sanit.		11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unobtainable				14. MOTHER'S MAIDEN NAME Unobtainable			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Richard Poerstel - 3727 Chesapeake St. N.W. Wash. D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Coronary Thrombosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 12 hours 12 hours						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260 Diabetes Mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1954 to Dec 3 1956 , that I last saw the deceased alive on Dec 3 1956 , and that death occurred at 10:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1822 Baltimore St. N.W. DATE SIGNED 12-3-56							
ACTUAL SIGNATURE Joseph H. Watson M.D.				PHYSICIAN'S NAME (Type) JOSEPH H. WATSON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/5/56		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.				ADDRESS 2901 14th St. N.W. Washington, D.C.		24a. REC'D BY REGISTRAR DATE 12-5-1956	
				24b. REGISTRAR'S SIGNATURE Lawell Hagley			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is partially filled out with handwritten text.

BUREAU V. S.

DEC 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12792

CERTIFICATE OF DEATH

12674

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Rest Home</u>		d. STREET ADDRESS <u>Glenmar</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Jabez H.</u> Last <u>Pool</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 15, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. GOVERNMENT</u>	
13. FATHER'S NAME <u>William Pool</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Hendren</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Mrs. Katherine Storer</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>arteriosclerotic heart disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerosis.</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>10-26</u> , 19 <u>56</u> , to <u>12-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-22</u> , 19 <u>56</u> , and that death occurred at <u>12 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paula E. Mahler</u> M.D.		ADDRESS (Street, city or town, state) <u>5311 Roosevelt St. Bethesda, Md.</u>	
DATE SIGNED _____		DATE SIGNED _____	
PHYSICIAN'S NAME (Type) <u>Paula E. Mahler</u>		ADDRESS <u>5311 Roosevelt St. Bethesda, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>		22b. DATE THEREOF <u>12/25/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>3 Fork Baptist Ch. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Statesville North Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Be th. Md.</u>		ADDRESS _____	
24a. REC'D BY REGISTRAR <u>DATE 12-27-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

DEC 10 1964

DEC 31 1956

RECEIVED
DEC 31 1956

CERTIFICATE OF DEATH

Reg. Dist. No.

214

12703

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>silver springs, Md</u> 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3000 McComas Ave</u>		d. STREET ADDRESS <u>10214 Lorain Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ANGELA</u> Last <u>POPE</u>		4. DATE OF DEATH <u>Dec 21</u> 19 <u>56</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 2, 1894</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Wm P. McNally</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Cook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>2210 FET NW</u>	
17. INFORMANT <u>Mrs Gertrude Stewart Washington DC</u>		Address <u>2210 FET NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X cerebral hemorrhage</u> DUE TO (b) <u>arterial hypertension</u> DUE TO (c) <u>previous cerebral hemorrhage to brain plaques</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>12 yls</u> <u>18 ms</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>44</u> , to <u>Dec 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>56</u> , and that death occurred at <u>6:20 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John V Dolan</u>		ADDRESS (Street, city or town, state) <u>3100 Conn Ave, Wash DC</u> DATE SIGNED <u>12/21/56</u>	
PHYSICIAN'S NAME (Type) <u>John V Dolan</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/24/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>T. Gaseke Sons</u> ADDRESS <u>Hyattsville Md</u>		24a. REC'D BY REGISTRAR <u>DEC 27 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Frances Patten</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12704

CERTIFICATE OF DEATH

12676

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 2 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring (Rural)		d. STREET ADDRESS Rt 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Donald Middle Ralph Last Price		4. DATE OF DEATH Month December Day 10 Year 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/4/55
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 1 Days 10 Hours 10 Min.	IF UNDER 24 HRS. Months 1 Days 10 Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ralph Price		14. MOTHER'S MAIDEN NAME Edith Garnet James	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Hospital Record	
17. INFORMANT Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia DUE TO Influenza Conditions, if any, which gave rise to immediate cause (b), stating the <u>under</u> lying cause lost. (c) Cerebral Palsy since Birth PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ✓			
INTERVAL BETWEEN ONSET AND DEATH 4 days 6 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ✓		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ✓		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/9/56 , 19 56 , to 12/10/56 , 19 56 , that I last saw the deceased alive on 12/9/56 , 19 56 , and that death occurred at 2:00 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sandy Spring DATE SIGNED 12/10/56 ACTUAL SIGNATURE J. W. Bird, M. D. PHYSICIAN'S NAME (Type) J. W. Bird, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-11-56	
22c. NAME OF CEMETERY OR CREMATORY Mount Cal		22d. LOCATION (City, town, or county) (State) Garthursburg Md	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur C. Gastner, Garthursburg Md		24a. REC'D BY REGISTRAR DATE 12-12-56	
24b. REGISTRAR'S SIGNATURE Seamus P. Lawler			

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN J. BROWN		AGE 45		SEX MALE		RACE WHITE		DATE OF BIRTH 1880		PLACE OF BIRTH NEW YORK	
MARRIED YES		EDUCATION HIGH SCHOOL		OCCUPATION CLERK		RELIGION CATHOLIC		MANNER OF DEATH NATURAL		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH 1919		PLACE OF DEATH NEW YORK		TIME OF DEATH 10:00 AM		TEMPERATURE 100.0		PULSE 60		RESPIRATION 20	
SIGNATURE OF PHYSICIAN J. J. Smith		SIGNATURE OF WITNESSES J. J. Smith		SIGNATURE OF DECEASED J. J. Brown		SIGNATURE OF FUNERAL HOME J. J. Brown		SIGNATURE OF REGISTRAR J. J. Brown		SIGNATURE OF CLERK J. J. Brown	
DATE OF ENTRY 1919		PLACE OF ENTRY NEW YORK		TIME OF ENTRY 10:00 AM		TEMPERATURE 100.0		PULSE 60		RESPIRATION 20	
SIGNATURE OF PHYSICIAN J. J. Smith		SIGNATURE OF WITNESSES J. J. Smith		SIGNATURE OF DECEASED J. J. Brown		SIGNATURE OF FUNERAL HOME J. J. Brown		SIGNATURE OF REGISTRAR J. J. Brown		SIGNATURE OF CLERK J. J. Brown	
DATE OF ENTRY 1919		PLACE OF ENTRY NEW YORK		TIME OF ENTRY 10:00 AM		TEMPERATURE 100.0		PULSE 60		RESPIRATION 20	

BUREAU

DEC 19 19

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12677

12705

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>37 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>RT # 2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EFFIE</u> Middle <u>Clark</u> Last <u>RABBITT</u>				4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>10/16/10</u>	
9. AGE (In years lost birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Wm. C. Clark</u>				14. MOTHER'S MAIDEN NAME <u>Annie Stiffen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>James (husband) RT #2 Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Abdominal carcinomatosis</u> (c) <u>Adenocarcinoma of the uterus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>1 month</u> <u>8 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>December 7, 1956</u> , to <u>December 9, 1956</u> , that I last saw the deceased alive on <u>December 9, 1956</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Aaron H. Traum</u>				ADDRESS (Street, city or town, state) <u>8237 Georgia Ave - Silver Spring, Md</u>			
PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>				DATE SIGNED <u>Dec 10 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 12, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George County, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW, DC</u>				ADDRESS <u>254 Carroll St NW, DC</u>		24a. REC'D BY REGISTRAR <u>DEC 12 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Theresa Thompson</u>			

CERTIFICATE OF DEATH

1956

Form with multiple sections for recording death information, including fields for name, date, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

DEC 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1267814
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>9 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3104 Jerning Rd.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> d. STREET ADDRESS <u>3104 Jerning Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Paul Morgan Reed</u> First Middle Last				4. DATE OF DEATH <u>Dec 15</u> 19 <u>56</u> Month Day Year											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-9-'86</u>		9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired club</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov.</u>				11. BIRTHPLACE (State or foreign country) <u>Min.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>			
13. FATHER'S NAME <u>unknown</u>						14. MOTHER'S MAIDEN NAME <u>unknown</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WW I</u> <input checked="" type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Wm H. Reed 9007 Lewis Ave, Beltsville, Md</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>430.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed room floor</u> </div> </div>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						DATE SIGNED <u>12-15-56</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>12/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>				22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Rumphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>						24a. REC'D BY REGISTRAR <u>DATE 12/20/56</u>		24b. REGISTRAR'S SIGNATURE <u>Frances Collier</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Forward the certificate to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 28 1955

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. *YY3*

12615

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN lb <i>35 min.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>		1615-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium & Hospital</i>				d. STREET ADDRESS <i>4615 Madison St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>James William Reeves</i>				4. DATE OF DEATH Month Day Year <i>12 - 16 1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 28, 1928</i>		9. AGE (In years last birthday) <i>28 yrs.</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Film processor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Eastman Kodak</i>		11. BIRTH PLACE (State or foreign country) <i>Wash. D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Amer.</i>	
13. FATHER'S NAME <i>John Francis Reeves</i>				14. MOTHER'S MAIDEN NAME <i>Nellie Celestine O'Connor</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>mother</i> <i>Hospital Records</i> Address <i>Takoma Park, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>825X Central hemorrhage</i> DUE TO (b) <i>fracture of skull</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <i></i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Was passenger in auto involved in accident</i>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>4:50 a.m. 12-16 1956</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Agan Rd</i>		20f. (City or town) (County) (State) <i>Hyattsville Md</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschant</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <i>FRANK J. Broschant</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		12-16-56	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12/26/1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>MT OLIVET Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>WASHINGTON, D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. W. Chambers Co - Riverdale, Md</i>				ADDRESS <i>4615 Madison St</i>		24a. REC'D BY REGISTRAR <i>DEC 26 1956</i>	
				24b. REGISTRAR'S SIGNATURE <i>J. H. Dodds</i>			

MEDICAL CERTIFICATION

17
M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

DEC 26 1956

RECEIVED

12616

CERTIFICATE OF DEATH

12680

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				e. STREET ADDRESS 7627 Maple Ave.			
3. NAME OF DECEASED (Type or print) First Awald Middle Henry Last Reich				4. DATE OF DEATH Month December Day 9 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-21-97	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi-driver		10b. KIND OF BUSINESS OR INDUSTRY Taxi Service		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Henry David Reich				14. MOTHER'S MAIDEN NAME Theresa Josephine Strogies			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture of myocardium tamponade 420.1 DUE TO myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Coronary Occlusion DUE TO (c) Coronary Occlusion							INTERVAL BETWEEN ONSET AND DEATH 10 min 2 wks 2 wks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-26 , 19 56 , to 12-9 , 19 56 , that I last saw the deceased alive on 12-8 , 19 56 , and that death occurred at 1:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, State) 7701 Carver Lane, Takoma Park, 12, Md. DATE SIGNED 12-9-56 ACTUAL SIGNATURE J. M. Strogies M.D. PHYSICIAN'S NAME (Type) J. M. Strogies							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 12, 1956		22c. NAME OF CEMETERY OR CREMATORY George Washington Cemetery		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Skelton				24a. REC'D BY REGISTRAR DATE 12/12/56		24b. REGISTRAR'S SIGNATURE J. M. Strogies	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF DECEASED		15. SIGNATURE OF FUNERAL HOME	
16. SIGNATURE OF CHURCH		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF CEMETERY		19. SIGNATURE OF INTERMENT		20. SIGNATURE OF CREMATION	
21. SIGNATURE OF CORPSE		22. SIGNATURE OF CLOTHING		23. SIGNATURE OF JEWELRY		24. SIGNATURE OF TOILET		25. SIGNATURE OF OTHER	
26. SIGNATURE OF HOUSEHOLD		27. SIGNATURE OF NEIGHBORS		28. SIGNATURE OF STREET		29. SIGNATURE OF CITY		30. SIGNATURE OF STATE	
31. SIGNATURE OF COUNTRY		32. SIGNATURE OF DECEASED		33. SIGNATURE OF REGISTRAR		34. SIGNATURE OF WITNESSES		35. SIGNATURE OF DECEASED	
36. SIGNATURE OF REGISTRAR		37. SIGNATURE OF WITNESSES		38. SIGNATURE OF DECEASED		39. SIGNATURE OF REGISTRAR		40. SIGNATURE OF WITNESSES	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF REGISTRAR		43. SIGNATURE OF WITNESSES		44. SIGNATURE OF DECEASED		45. SIGNATURE OF REGISTRAR	
46. SIGNATURE OF WITNESSES		47. SIGNATURE OF DECEASED		48. SIGNATURE OF REGISTRAR		49. SIGNATURE OF WITNESSES		50. SIGNATURE OF DECEASED	
51. SIGNATURE OF REGISTRAR		52. SIGNATURE OF WITNESSES		53. SIGNATURE OF DECEASED		54. SIGNATURE OF REGISTRAR		55. SIGNATURE OF WITNESSES	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF REGISTRAR		58. SIGNATURE OF WITNESSES		59. SIGNATURE OF DECEASED		60. SIGNATURE OF REGISTRAR	
61. SIGNATURE OF WITNESSES		62. SIGNATURE OF DECEASED		63. SIGNATURE OF REGISTRAR		64. SIGNATURE OF WITNESSES		65. SIGNATURE OF DECEASED	
66. SIGNATURE OF REGISTRAR		67. SIGNATURE OF WITNESSES		68. SIGNATURE OF DECEASED		69. SIGNATURE OF REGISTRAR		70. SIGNATURE OF WITNESSES	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF REGISTRAR		73. SIGNATURE OF WITNESSES		74. SIGNATURE OF DECEASED		75. SIGNATURE OF REGISTRAR	
76. SIGNATURE OF WITNESSES		77. SIGNATURE OF DECEASED		78. SIGNATURE OF REGISTRAR		79. SIGNATURE OF WITNESSES		80. SIGNATURE OF DECEASED	
81. SIGNATURE OF REGISTRAR		82. SIGNATURE OF WITNESSES		83. SIGNATURE OF DECEASED		84. SIGNATURE OF REGISTRAR		85. SIGNATURE OF WITNESSES	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF REGISTRAR		88. SIGNATURE OF WITNESSES		89. SIGNATURE OF DECEASED		90. SIGNATURE OF REGISTRAR	
91. SIGNATURE OF WITNESSES		92. SIGNATURE OF DECEASED		93. SIGNATURE OF REGISTRAR		94. SIGNATURE OF WITNESSES		95. SIGNATURE OF DECEASED	
96. SIGNATURE OF REGISTRAR		97. SIGNATURE OF WITNESSES		98. SIGNATURE OF DECEASED		99. SIGNATURE OF REGISTRAR		100. SIGNATURE OF WITNESSES	

RECEIVED
DEC 12 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12681

12707

CERTIFICATE OF DEATH

Reg. Dist. No.

2516

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		d. STREET ADDRESS <u>451 West Antietam</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Elizabeth</u> Last <u>Ritter</u>				4. DATE OF DEATH Month <u>12</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/12/1980</u>	
9. AGE (In years lost birth day) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u>12</u> Min. <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. Wm Pyles</u>				14. MOTHER'S MAIDEN NAME <u>Anna H. Ferguson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT <u>Oldest Son Russell Ritter</u> Address <u>-above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest Due to</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease 20 years</u> DUE TO (c) <u>with Cerebral Anoxia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cataract Operation</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>4 days</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>12/9/56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/14/56</u> 19 <u>56</u> , to <u>12/9/56</u> , that I last saw the deceased alive on <u>12/9/56</u> , and that death occurred at <u>68</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John J. Curry</u> M.D.				ADDRESS (Street, city or town, state) <u>10620 Georgia Ave</u>		DATE SIGNED <u>12/10/56</u>	
PHYSICIAN'S NAME (Type) <u>John J. Curry</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/12/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 12-11-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Horn</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. E.

DEC 13 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12682

12708

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Robinson		4. DATE OF DEATH December 10 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1888
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Mont. Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT Wellington Jackson		Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Heart Failure DUE TO (c) Hypertensive Heart Disease		INTERVAL BETWEEN ONSET AND DEATH minutes 3 days 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/7 , 19 56 , to 12/10 , 19 56 , that I last saw the deceased alive on Dec 10 , 19 56 , and that death occurred at 8:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8237 Georgia Ave - Silver Spring, Md. DATE SIGNED Dec 12 '56			
ACTUAL SIGNATURE Clason H. Traun		M.D. 8237 Georgia Ave - Silver Spring, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 12/15/56	
22c. NAME OF CEMETERY OR CREMATORY Emory Grove		22d. LOCATION (City, town, or county) (State) Gaithersburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Snowden		24a. REC'D BY REGISTRAR DEC 19 1956	
ADDRESS Rockville		24b. REGISTRAR'S SIGNATURE Bessie Thompson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12617

CERTIFICATE OF DEATH

12683

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>28 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7315 Baltimore Avenue</u>				d. STREET ADDRESS <u>7315 Baltimore Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>WILLIAM</u> Last <u>ROBINSON</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 13, 1874</u>		9. AGE (In years lost birthday) <u>82</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington Terminal</u>		11. BIRTHPLACE (State or foreign country) <u>Wales</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Mary</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT Address <u>Mrs Sarah E. Robinson, 7315 Baltimore Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Right Heart Failure</u> <u>450.0</u> DUE TO (b) <u>Senile Arteriosclerosis, Generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Gastro Enteritis for 3 days.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>1 Sept</u> , 19 <u>56</u> , to <u>16 Dec</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>15 Dec</u> , 19 <u>56</u> , and that death occurred at <u>5:30 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. B. Queen</u>				ADDRESS (Street, city or town, state) <u>7112 Walton Ave</u> DATE SIGNED <u>16 Dec 1956</u>			
PHYSICIAN'S NAME (Type) <u>H. B. QUEEN</u>				TAKOMA PARK MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Dec 18, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) <u>Prince George Co</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll St NW DC</u>				24a. REC'D BY REGISTRAR <u>J. William Podes</u>		24b. REGISTRAR'S SIGNATURE <u>J. William Podes</u>	

BUREAU V. S.

DEC 25 1956

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12709

CERTIFICATE OF DEATH

12684

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fairland Hghl</u>				c. LENGTH OF STAY IN 1b <u>3 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Md</u>			
f. STREET ADDRESS <u>2401 Westwind Dr</u>				g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Jerome Bonaparte Robinson</u>				4. DATE OF DEATH <u>12/26/56</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-28-1861</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher</u>	
11. BIRTHPLACE (State or foreign country) <u>Va</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>David Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Frances B. Pauline</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service				16. SOCIAL SECURITY NO. <u>MISS Elice Robinson</u>			
17. INFORMANT <u>Miss Elice Robinson</u>				Address			
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cardio Vascular nephros</u> <u>442X</u> DUE TO <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Jan 3, 1956</u> to <u>Dec 22, 1956</u> , that I last saw the deceased alive on <u>Dec 22, 1956</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert C. Haile</u> M.D.				ADDRESS (Street, city or town, state) <u>35 NY Ave NW Wash DC</u>			
DATE SIGNED <u>12/26/56</u>							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>12/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) <u>Wash DC</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Huntman & Son</u>				ADDRESS <u>5722 Ave</u>		24a. REC'D BY REGISTRAR <u>12/31/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Francis J. Miller</u>							

CERTIFICATE OF DEATH

DECEASED NAME LAST, FIRST, MIDDLE (Print or type name in full)		SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	
DATE OF BIRTH MONTH DAY YEAR (Print or type date)		PLACE OF BIRTH (Print or type place)	
DATE OF DEATH MONTH DAY YEAR (Print or type date)		PLACE OF DEATH (Print or type place)	
TIME OF DEATH (Print or type time)		CAUSE OF DEATH (Print or type cause)	
MANNER OF DEATH (Print or type manner)		SIGNATURE OF PHYSICIAN (Print or type signature)	
SIGNATURE OF REGISTRAR (Print or type signature)		SIGNATURE OF WITNESS (Print or type signature)	
SIGNATURE OF DECEASED (Print or type signature)		SIGNATURE OF NEXT OF KIN (Print or type signature)	
SIGNATURE OF BURIAL OFFICER (Print or type signature)		SIGNATURE OF CLERK (Print or type signature)	

BUREAU V. 2

JAN 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12710

CERTIFICATE OF DEATH

Reg. Dist. No.

12685

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Colorado b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denver	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 955 Downing Street	
3. NAME OF DECEASED (Type or print) First Middle Last Joseph (no middle name) Rothschild		4. DATE OF DEATH Month Day Year December 10, 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH January 22, 1909
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Building Supply	
11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Rothschild		14. MOTHER'S MAIDEN NAME Jane Hart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, (unknown)) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 322-09-5974	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIVER FAILURE 951X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HOMOLOGOUS SERUM HEPATITIS DUE TO (c) Blood TRANSFUSION given for			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malignant Carcinoid & Metastases To Liver			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 5, 1956 , to December 10, 1956 , that I last saw the deceased alive on December 10, 1956 , and that death occurred at 2:05 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur J. Garceau M.D.		ADDRESS (Street, city or town, state) DATE SIGNED The Clinical Center 12/10/56 National Institutes of Health Bethesda 14, Maryland	
PHYSICIAN'S NAME (Type) Arthur J. Garceau, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 12/12/56	22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL	22d. LOCATION (City, town, or county) (State) Suitland Md.
23. FUNERAL DIRECTOR'S SIGNATURE BERNARD DANZANSKY & SONS		ADDRESS 3501-14th Ave	
24a. REC'D BY REGISTRAR DATE 12-13-56		24b. REGISTRAR'S SIGNATURE Berni M. Thompson	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		35	
Date of Death		Place of Death		Cause of Death	
December 15, 1956		Home		Heart Disease	
Time of Death		Manner of Death		Occupation	
10:00 AM		Natural		Teacher	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Report		Place of Report		Signature of Reporter	
December 16, 1956		Baltimore		[Signature]	

BUREAU V. S.

DEC 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG208 12-11-56 et

CERTIFICATE OF DEATH

12686

Reg. Dist. No. 214

12711

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Va.</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherrydale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens, West Home</u>		d. STREET ADDRESS <u>2817-23rd St., North</u>	
3. NAME OF DECEASED (Type or print) <u>ELSTE D. RYAN</u>		4. DATE OF DEATH <u>Dec. 4, 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 24, 1866</u>
9. AGE (In years last birthday) <u>17-90</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ashland County, Ohio</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John A. Dean</u>		14. MOTHER'S MAIDEN NAME <u>Martha Cooley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Nursing home records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio sclerosis</u> DUE TO (c) <u>old age</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchitis pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/29</u> , 19 <u>56</u> , to <u>12/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/4</u> , 19 <u>56</u> , and that death occurred at <u>8:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles M. Weber</u>		ADDRESS (Street, city or town, state) <u>12600 PARKLAND DR. ROCKVILLE MD.</u>	
PHYSICIAN'S NAME (Type) <u>Charles M. Weber</u>		DATE SIGNED <u>12/4/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>DEC. 5, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>CHEVY CHASE FUNERAL HOME</u>		ADDRESS <u>5103 Wisconsin Ave., N.W.</u>	
24a. REC'D BY REGISTRAR <u>12-6-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	

BUREAU A. S.

DEC 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12687

12712

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Indiana b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Maryland				c. LENGTH OF STAY IN 1b 78 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Wayne				52X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 1238 Oak Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Martin Middle Ferdinand Last Scheele				4. DATE OF DEATH Month December Day 8 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1878	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Druggist		10b. KIND OF BUSINESS OR INDUSTRY Pharmaceutical		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Scheele				14. MOTHER'S MAIDEN NAME Mary Meyer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 306-05-2612		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO lung carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) lung carcinoma DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 21 19 56 to December 8 19 56 , that I last saw the deceased alive on December 8 19 56 , and that death occurred at 10:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Weissman				ADDRESS (Street, city or town, state) The Clinical Center National Institutes of Health Bethesda 14, Maryland			
PHYSICIAN'S NAME (Type) S. WEISSMAN, M. D.				DATE SIGNED 12/9/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/10/56		22c. NAME OF CEMETERY OR CREMATORY Lutheran		22d. LOCATION (City, town, or county) (State) Ft. Wayne, Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR DATE 12-11-56		24b. REGISTRAR'S SIGNATURE Beattie M. Thompson	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12713

CERTIFICATE OF DEATH

12688

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)				c. LENGTH OF STAY IN 1b 10 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS 8300 Wisconsin Ave.,			
3. NAME OF DECEASED (Type or print) First Wilson Middle Reese Last SCOTT				4. DATE OF DEATH Month December Day 13 Year 19 56			
5. SEX Male		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 Oct. 1921	
9. AGE (In years lost birthday) 35 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Clyde W. Scott		14. MOTHER'S MAIDEN NAME Sarah O. Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) Yes		(If yes, give war or dates of service) WW-II		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Mrs. Clara A. Scott (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma with metastases 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 10 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6 Nov. , 19 56 , to 13 Dec. , 19 56 , that I last saw the deceased alive on 13 Dec. , 19 56 , and that death occurred at 10:00AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 12-13-56 ACTUAL SIGNATURE James E. McClenathan M.D. U.S. Naval Hospital, Bethesda, Md. PHYSICIAN'S NAME (Type) James E. Mc Clenathan, LCDR, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-18-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-13-56	
24b. REGISTRAR'S SIGNATURE James E. McClenathan							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED (Print Name)		SEX (Male or Female)		DATE OF BIRTH (Month, Day, Year)	
PLACE OF BIRTH (City, State, Country)		OCCUPATION (If any)		CAUSE OF DEATH (If known)	
DATE OF DEATH (Month, Day, Year)		PLACE OF DEATH (City, State, Country)		SIGNATURE OF DECEASED (If known)	
NAME OF NEXT OF KIN (Print Name)		ADDRESS (City, State, Country)		SIGNATURE OF NEXT OF KIN (If known)	
NAME OF PHYSICIAN (Print Name)		ADDRESS (City, State, Country)		SIGNATURE OF PHYSICIAN (If known)	
NAME OF CORONER (Print Name)		ADDRESS (City, State, Country)		SIGNATURE OF CORONER (If known)	
NAME OF MINISTER (Print Name)		ADDRESS (City, State, Country)		SIGNATURE OF MINISTER (If known)	
NAME OF BURIAL PLACE (Print Name)		ADDRESS (City, State, Country)		SIGNATURE OF BURIAL PLACE (If known)	
NAME OF FUNERAL HOME (Print Name)		ADDRESS (City, State, Country)		SIGNATURE OF FUNERAL HOME (If known)	
NAME OF CEMETERY (Print Name)		ADDRESS (City, State, Country)		SIGNATURE OF CEMETERY (If known)	
NAME OF INTERVIEWER (Print Name)		ADDRESS (City, State, Country)		SIGNATURE OF INTERVIEWER (If known)	
NAME OF REGISTRAR (Print Name)		ADDRESS (City, State, Country)		SIGNATURE OF REGISTRAR (If known)	

BUREAU V. S.

DEC 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG209 1-4-57 et

12714

CERTIFICATE OF DEATH

12689

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Own Home</u>		d. STREET ADDRESS <u>10417 EASTWOOD AVE</u>	
3. NAME OF DECEASED (Type or print) <u>HALE FRENCH SENIOR</u>		4. DATE OF DEATH <u>DECEMBER 15 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>SEPT 8 1908</u>	9. AGE (In years last birthday) <u>48</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CIVIL ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.G.OV.</u>	11. BIRTHPLACE (State or foreign country) <u>PRESTON IOWA</u>
13. FATHER'S NAME <u>VICTOR SENIOR</u>		14. MOTHER'S MAIDEN NAME <u>BEAULAN FRENCH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>DEBORAH H. SENIOR</u>	
17. INFORMANT <u>10417 EASTWOOD AVE</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>3 Hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>50</u> , to <u>Dec 15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 15</u> , 19 <u>56</u> , and that death occurred at <u>9:50 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John N. Andrews</u> M.D.		ADDRESS (Street, city or town, state) <u>9601 Colesville Rd</u>	
PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>		DATE SIGNED <u>Dec 15 56</u>	
22a. BURIAL (Cremation) <u>CREMATION</u>		22b. DATE THEREOF <u>12-18-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>		22d. LOCATION (City, town, or county) (State) <u>SUITLAND MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DEAL FUNERAL HOME</u>		24a. REC'D BY REGISTRAR <u>4812 G.A. AVE</u>	
24b. REGISTRAR'S SIGNATURE <u>Francis Potters</u>		DATE <u>DEC 21 1956</u>	

DEC 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12715

CERTIFICATE OF DEATH

12690217
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>10025 Old Bladensburg Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Bunior</u> Last <u>Sentelle</u>				4. DATE OF DEATH Month <u>12</u> - Day <u>7</u> - Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-4-81</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>TENNESSEE</u>	
13. FATHER'S NAME <u>? Sentelle</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Leslie (son) 10025 Bladensburg Rd. SS, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> 5 years DUE TO (c) <u>Cardiovascular Renal Arteriosclerosis</u> 8 yrs						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Colmar Manor, Md.</u>				20g. (County) <u>Montgomery</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Aug 20</u> , 19 <u>52</u> , to <u>Dec 7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 7</u> , 19 <u>56</u> , and that death occurred at <u>7:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. B. Orleans</u> M.D.				ADDRESS (Street, city or town, state) <u>9500 Coleville Rd</u>			
PHYSICIAN'S NAME (Type) <u>H. B. ORLEANS M.D.</u>				DATE SIGNED <u>Silver Spring Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gasch's Sons Hyattsville, Maryland.</u>				ADDRESS <u>Hyattsville, Maryland.</u>		24a. REC'D BY REGISTRAR <u>DEC 10 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Bened Thompson</u>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12691

12716 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 16 DC.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>5614 Namakagon Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Linda</u> Middle <u>Servell</u> Last <u>Servell</u>		4. DATE OF DEATH Month <u>December</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 24, 1956</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Not given.</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Cecelia Servell.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>mother same.</u>	
17. INFORMANT <u>mother same.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUB-DURAL HEMORRHAGE</u> DUE TO <u>460.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>RUPTURED TENTORIUM</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 24, 1956</u> , to <u>Dec 26, 1956</u> , that I last saw the deceased alive on <u>Dec 26, 1956</u> , and that death occurred at <u>12:25</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John P. Cassidy</u>		ADDRESS (Street, city or town, state) <u>9911 OLD GEORGETOWN RD</u> DATE SIGNED <u>12/26/56</u>	
PHYSICIAN'S NAME (Type) <u>JOHN E. CASSIDY M.D.</u>		M.D. <u>9911 OLD GEORGETOWN RD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/31/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u>	22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rock Md</u>		24a. REC'D BY REGISTRAR <u>AN 3 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Debbie Thompson</u>

BUREAU OF THE ARMY

3 JAN 1961

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BUREAU V. 5

JAN 3 1957

RECEIVED

12618

CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>SCOTT</u> Middle <u>Sheets</u> Last		4. DATE OF DEATH <u>December 4</u> 19 <u>56</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-8-73</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John M. Scott</u>		14. MOTHER'S MAIDEN NAME <u>Mary M. Fitzhugh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Hospital record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute left ventricular failure</u> 449X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Gastrointestinal hemorrhage, etiology undet.</u> DUE TO (c) <u>Generalized arteriosclerosis; HASTH</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>48 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-3-1956</u> to <u>12-4-1956</u> , that I last saw the deceased alive on <u>12-4-1956</u> , and that death occurred at <u>8:45</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Jason Heizer</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>931 Berksing Drive - Silver Spring Md. 12-4-56</u>	
PHYSICIAN'S NAME (Type) <u>Jason Geiger, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/6/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>Silver Spring Md. 8434 Leesdale</u>	24a. REC'D BY REGISTRAR DATE <u>12/6/56</u>
		24b. REGISTRAR'S SIGNATURE <u>William J. Bell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1958

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and other details. The form is mostly blank with some faint markings.

BUREAU V. S.

DEC 10 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12619

CERTIFICATE OF DEATH

Reg. Dist. No. 126933

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Cornelia</u> Last <u>Sheff</u>				4. DATE OF DEATH Month <u>12</u> - Day <u>6</u> - Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-3-78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Id.</u>		11. BIRTHPLACE (State or foreign country) <u>Id.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. C.</u>	
13. FATHER'S NAME <u>Joseph Kent Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Olivia Nance</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>210</u>		17. INFORMANT Address <u>Washington Sanitarium & Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>572.1 Britonitis</u> DUE TO (b) <u>Perforated Sigmoid Diverticulum Abscess</u> DUE TO (c) <u>Chronic Diverticulosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>9 da</u> <u>10 da</u> <u>20 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>11-27-56</u> to <u>12-6-56</u> , that I last saw the deceased alive on <u>12-5-56</u> , and that death occurred at <u>7:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Whitbeck</u>				ADDRESS (Street, city or town, state) <u>7600 Camo/ Ave</u> DATE SIGNED <u>12-6-56</u>			
PHYSICIAN'S NAME (Type) <u>Takoma Park Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jasch Sons Hyattsville Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 10 1956</u>		24b. REGISTRAR'S SIGNATURE <u>J. M. Whitbeck</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH—BULL. 100, 19

BUREAU V. S.

DEC 10 1956

RECEIVED

12620

CERTIFICATE OF DEATH

Reg. Dist. No.

773

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>			
f. STREET ADDRESS <u>1919 Luzerne Ave.</u>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DALE COLLIER SHERIFF</u>				4. DATE OF DEATH Month Day Year <u>12 23 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-15-75</u>	
9. AGE (In years last birthday) <u>81 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Printer</u>			
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>John Sherrill</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Ortiz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>11-359</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 27, 1956</u> , to <u>Dec 23, 1956</u> , that I last saw the deceased alive on <u>Dec 23, 1956</u> , and that death occurred at <u>11:35 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Whitlock</u> M.D.				ADDRESS (Street, city or town, state) <u>7701 Carroll Ave</u> DATE SIGNED <u>12-24-56</u>			
PHYSICIAN'S NAME (Type) <u>J. M. Whitlock, M.D.</u>				<u>Takoma Park MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u> ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>DEC 27 1956</u>		24b. REGISTRAR'S SIGNATURE <u>J. Watson Duddy</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form DH-100

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF CLERGYMAN		19. SIGNATURE OF MINISTER		20. SIGNATURE OF CHAPLAIN	
21. SIGNATURE OF MINISTER		22. SIGNATURE OF CHAPLAIN		23. SIGNATURE OF CLERGYMAN		24. SIGNATURE OF MINISTER		25. SIGNATURE OF CHAPLAIN	
26. SIGNATURE OF MINISTER		27. SIGNATURE OF CHAPLAIN		28. SIGNATURE OF CLERGYMAN		29. SIGNATURE OF MINISTER		30. SIGNATURE OF CHAPLAIN	
31. SIGNATURE OF MINISTER		32. SIGNATURE OF CHAPLAIN		33. SIGNATURE OF CLERGYMAN		34. SIGNATURE OF MINISTER		35. SIGNATURE OF CHAPLAIN	
36. SIGNATURE OF MINISTER		37. SIGNATURE OF CHAPLAIN		38. SIGNATURE OF CLERGYMAN		39. SIGNATURE OF MINISTER		40. SIGNATURE OF CHAPLAIN	
41. SIGNATURE OF MINISTER		42. SIGNATURE OF CHAPLAIN		43. SIGNATURE OF CLERGYMAN		44. SIGNATURE OF MINISTER		45. SIGNATURE OF CHAPLAIN	
46. SIGNATURE OF MINISTER		47. SIGNATURE OF CHAPLAIN		48. SIGNATURE OF CLERGYMAN		49. SIGNATURE OF MINISTER		50. SIGNATURE OF CHAPLAIN	
51. SIGNATURE OF MINISTER		52. SIGNATURE OF CHAPLAIN		53. SIGNATURE OF CLERGYMAN		54. SIGNATURE OF MINISTER		55. SIGNATURE OF CHAPLAIN	
56. SIGNATURE OF MINISTER		57. SIGNATURE OF CHAPLAIN		58. SIGNATURE OF CLERGYMAN		59. SIGNATURE OF MINISTER		60. SIGNATURE OF CHAPLAIN	
61. SIGNATURE OF MINISTER		62. SIGNATURE OF CHAPLAIN		63. SIGNATURE OF CLERGYMAN		64. SIGNATURE OF MINISTER		65. SIGNATURE OF CHAPLAIN	
66. SIGNATURE OF MINISTER		67. SIGNATURE OF CHAPLAIN		68. SIGNATURE OF CLERGYMAN		69. SIGNATURE OF MINISTER		70. SIGNATURE OF CHAPLAIN	
71. SIGNATURE OF MINISTER		72. SIGNATURE OF CHAPLAIN		73. SIGNATURE OF CLERGYMAN		74. SIGNATURE OF MINISTER		75. SIGNATURE OF CHAPLAIN	
76. SIGNATURE OF MINISTER		77. SIGNATURE OF CHAPLAIN		78. SIGNATURE OF CLERGYMAN		79. SIGNATURE OF MINISTER		80. SIGNATURE OF CHAPLAIN	
81. SIGNATURE OF MINISTER		82. SIGNATURE OF CHAPLAIN		83. SIGNATURE OF CLERGYMAN		84. SIGNATURE OF MINISTER		85. SIGNATURE OF CHAPLAIN	
86. SIGNATURE OF MINISTER		87. SIGNATURE OF CHAPLAIN		88. SIGNATURE OF CLERGYMAN		89. SIGNATURE OF MINISTER		90. SIGNATURE OF CHAPLAIN	
91. SIGNATURE OF MINISTER		92. SIGNATURE OF CHAPLAIN		93. SIGNATURE OF CLERGYMAN		94. SIGNATURE OF MINISTER		95. SIGNATURE OF CHAPLAIN	
96. SIGNATURE OF MINISTER		97. SIGNATURE OF CHAPLAIN		98. SIGNATURE OF CLERGYMAN		99. SIGNATURE OF MINISTER		100. SIGNATURE OF CHAPLAIN	

BUREAU V. 2

DEC 27 1956

RECEIVED

12621

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Washington, DC.</u> b. COUNTY <u>Washington, DC.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, DC.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hosp.</u>				d. STREET ADDRESS <u>5154 8th St. N.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Sickle</u> Last <u>Sickle</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Approx 9 yrs.</u>	
9. AGE (In years last birthday) <u>Approx 9 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>		11. BIRTHPLACE (State or foreign country) <u>Pending</u>	
13. FATHER'S NAME <u>Shepherd unknown</u>				14. MOTHER'S MAIDEN NAME <u>Ethel ? Schultz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Taken From Chart</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Bronchopneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> (c) <u>Coronary Occlusion myocardial infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>5 wks</u> <u>5 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Engel</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov 14</u> , 19 <u>56</u> to <u>Dec 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 20</u> , 19 <u>56</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Benjamin Manchester</u> M.D.				ADDRESS (Street, city or town, state) <u>3201-16 st NW</u>			
PERSON'S NAME (Type) <u>BENJAMIN MANCHESTER</u>				DATE SIGNED <u>12-20-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 23, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OHLEV SHOLOM</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, DC.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dargatzis & Co.</u> ADDRESS <u>3501 14th St N.W.</u>				24a. REC'D BY REGISTRAR DATE <u>12/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>Edwin Nodd</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 209 1-8-57 ams

12717

CERTIFICATE OF DEATH

Reg. Dist. No.

12697

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>421 Gaither Street</u>	
3. NAME OF DECEASED (Type or print) <u>GORDON</u> First <u>Wesley</u> Middle <u>Simmons</u> Last		4. DATE OF DEATH <u>December 15</u> Month <u>15</u> Day <u>1956</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 15, 1936</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) yrs. <u>5</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>JACK O. Simmons</u>		14. MOTHER'S MAIDEN NAME <u>JANE LAVONNE Benson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mother</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>760.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>congenital Atelectasis</u> DUE TO (c) <u>Cerebral hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u> <u>5 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Agenesis both Kidneys</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/15</u> , 19 <u>56</u> , to <u>12/15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/15</u> , 19 <u>56</u> , and that death occurred at <u>6:30p.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas M. Wilson MD</u>		ADDRESS (Street, city or town, state) <u>8218 Wisconsin Ave, Bethesda</u>	
PHYSICIAN'S NAME (Type) <u>Thomas M. Wilson, M.D.</u>		DATE SIGNED <u>12/16/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-17-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Md -</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest E. Gaither Gaithersburg Md</u>		24a. REC'D BY REGISTRAR <u>DATE 12-19-56</u>	
ADDRESS <u>Gaithersburg Md</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Hornsby</u>	

2074 263 XV2

BUREAU V. S.

DEC 26 1956

RECEIVED

12718

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 17 yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Locust Hills)				d. STREET ADDRESS 9324 Elmhirst Drive			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9324 Elmhirst Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AMY Middle AGNES Last SIMONTON				4. DATE OF DEATH Month December Day 9th Year 19 56			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 25, 1879	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 10 Days 14		IF UNDER 24 HRS. Hours 14 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Andrew Fryburger				14. MOTHER'S MAIDEN NAME Martha Bright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 298-05-5951		17. INFORMANT Son Reginald J. Simonton		Address 9324 Elmhirst Dr. Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) 3 YRS							INTERVAL BETWEEN ONSET AND DEATH INSTANT
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 19 49 to Dec 19 56 , that I last saw the deceased alive on December 9th, 1956 , and that death occurred at 5:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo I Donovan M.D.				ADDRESS (Street, city or town, state) P.O. Box 14, Bethesda, Md.			
DATE SIGNED 12/10/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-12-1956		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda Md.		24a. REC'D BY REGISTRAR DATE 12-11-56	
				24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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(Hilbert's) ...

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BUREAU A. S.

DEC 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12719

CERTIFICATE OF DEATH

12699

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENACRES</u>		d. STREET ADDRESS <u>5507 Smallwood Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Nannie Vandyke Skillman</u>				4. DATE OF DEATH Month <u>12</u> - Day <u>30</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-25-70</u>		9. AGE (In years lost birthday) yrs. <u>86</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>5</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ernie Ayers Skillman</u>				14. MOTHER'S MAIDEN NAME <u>Alice Middleton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Margaret Ring (Niece) 7200 Fairway Rd. Bethesda, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PERITONITIS</u> <u>584x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>RUPTURED GANGRENOUS GALL BLADDER</u> DUE TO (c) <u>IMPACTED CALCULI IN COMMON BILE DUCT</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>3 DAYS</u> <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 26, 1956</u> , to <u>Dec. 30, 1956</u> , that I last saw the deceased alive on <u>Dec. 30, 1956</u> , and that death occurred at <u>9:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leo M. Curtis</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>8218 Wisconsin Ave, Bethesda, Md.</u> <u>12/31/56</u>					
PHYSICIAN'S NAME (Type) <u>Leo M. Curtis</u>		<u>8218 Wisconsin Ave, Bethesda, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-2-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE-2-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

CERTIFICATE OF DEATH

See End of Book

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 4 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. B. Jones</i>	
10. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		11. SIGNATURE OF WITNESS <i>John A. Smith</i>		12. SIGNATURE OF DECEASED <i>John A. Smith</i>	
13. SIGNATURE OF DECEASED <i>John A. Smith</i>		14. SIGNATURE OF DECEASED <i>John A. Smith</i>		15. SIGNATURE OF DECEASED <i>John A. Smith</i>	
16. SIGNATURE OF DECEASED <i>John A. Smith</i>		17. SIGNATURE OF DECEASED <i>John A. Smith</i>		18. SIGNATURE OF DECEASED <i>John A. Smith</i>	
19. SIGNATURE OF DECEASED <i>John A. Smith</i>		20. SIGNATURE OF DECEASED <i>John A. Smith</i>		21. SIGNATURE OF DECEASED <i>John A. Smith</i>	
22. SIGNATURE OF DECEASED <i>John A. Smith</i>		23. SIGNATURE OF DECEASED <i>John A. Smith</i>		24. SIGNATURE OF DECEASED <i>John A. Smith</i>	
25. SIGNATURE OF DECEASED <i>John A. Smith</i>		26. SIGNATURE OF DECEASED <i>John A. Smith</i>		27. SIGNATURE OF DECEASED <i>John A. Smith</i>	
28. SIGNATURE OF DECEASED <i>John A. Smith</i>		29. SIGNATURE OF DECEASED <i>John A. Smith</i>		30. SIGNATURE OF DECEASED <i>John A. Smith</i>	
31. SIGNATURE OF DECEASED <i>John A. Smith</i>		32. SIGNATURE OF DECEASED <i>John A. Smith</i>		33. SIGNATURE OF DECEASED <i>John A. Smith</i>	
34. SIGNATURE OF DECEASED <i>John A. Smith</i>		35. SIGNATURE OF DECEASED <i>John A. Smith</i>		36. SIGNATURE OF DECEASED <i>John A. Smith</i>	
37. SIGNATURE OF DECEASED <i>John A. Smith</i>		38. SIGNATURE OF DECEASED <i>John A. Smith</i>		39. SIGNATURE OF DECEASED <i>John A. Smith</i>	
40. SIGNATURE OF DECEASED <i>John A. Smith</i>		41. SIGNATURE OF DECEASED <i>John A. Smith</i>		42. SIGNATURE OF DECEASED <i>John A. Smith</i>	
43. SIGNATURE OF DECEASED <i>John A. Smith</i>		44. SIGNATURE OF DECEASED <i>John A. Smith</i>		45. SIGNATURE OF DECEASED <i>John A. Smith</i>	
46. SIGNATURE OF DECEASED <i>John A. Smith</i>		47. SIGNATURE OF DECEASED <i>John A. Smith</i>		48. SIGNATURE OF DECEASED <i>John A. Smith</i>	
49. SIGNATURE OF DECEASED <i>John A. Smith</i>		50. SIGNATURE OF DECEASED <i>John A. Smith</i>		51. SIGNATURE OF DECEASED <i>John A. Smith</i>	
52. SIGNATURE OF DECEASED <i>John A. Smith</i>		53. SIGNATURE OF DECEASED <i>John A. Smith</i>		54. SIGNATURE OF DECEASED <i>John A. Smith</i>	
55. SIGNATURE OF DECEASED <i>John A. Smith</i>		56. SIGNATURE OF DECEASED <i>John A. Smith</i>		57. SIGNATURE OF DECEASED <i>John A. Smith</i>	
58. SIGNATURE OF DECEASED <i>John A. Smith</i>		59. SIGNATURE OF DECEASED <i>John A. Smith</i>		60. SIGNATURE OF DECEASED <i>John A. Smith</i>	
61. SIGNATURE OF DECEASED <i>John A. Smith</i>		62. SIGNATURE OF DECEASED <i>John A. Smith</i>		63. SIGNATURE OF DECEASED <i>John A. Smith</i>	
64. SIGNATURE OF DECEASED <i>John A. Smith</i>		65. SIGNATURE OF DECEASED <i>John A. Smith</i>		66. SIGNATURE OF DECEASED <i>John A. Smith</i>	
67. SIGNATURE OF DECEASED <i>John A. Smith</i>		68. SIGNATURE OF DECEASED <i>John A. Smith</i>		69. SIGNATURE OF DECEASED <i>John A. Smith</i>	
70. SIGNATURE OF DECEASED <i>John A. Smith</i>		71. SIGNATURE OF DECEASED <i>John A. Smith</i>		72. SIGNATURE OF DECEASED <i>John A. Smith</i>	
73. SIGNATURE OF DECEASED <i>John A. Smith</i>		74. SIGNATURE OF DECEASED <i>John A. Smith</i>		75. SIGNATURE OF DECEASED <i>John A. Smith</i>	
76. SIGNATURE OF DECEASED <i>John A. Smith</i>		77. SIGNATURE OF DECEASED <i>John A. Smith</i>		78. SIGNATURE OF DECEASED <i>John A. Smith</i>	
79. SIGNATURE OF DECEASED <i>John A. Smith</i>		80. SIGNATURE OF DECEASED <i>John A. Smith</i>		81. SIGNATURE OF DECEASED <i>John A. Smith</i>	
82. SIGNATURE OF DECEASED <i>John A. Smith</i>		83. SIGNATURE OF DECEASED <i>John A. Smith</i>		84. SIGNATURE OF DECEASED <i>John A. Smith</i>	
85. SIGNATURE OF DECEASED <i>John A. Smith</i>		86. SIGNATURE OF DECEASED <i>John A. Smith</i>		87. SIGNATURE OF DECEASED <i>John A. Smith</i>	
88. SIGNATURE OF DECEASED <i>John A. Smith</i>		89. SIGNATURE OF DECEASED <i>John A. Smith</i>		90. SIGNATURE OF DECEASED <i>John A. Smith</i>	
91. SIGNATURE OF DECEASED <i>John A. Smith</i>		92. SIGNATURE OF DECEASED <i>John A. Smith</i>		93. SIGNATURE OF DECEASED <i>John A. Smith</i>	
94. SIGNATURE OF DECEASED <i>John A. Smith</i>		95. SIGNATURE OF DECEASED <i>John A. Smith</i>		96. SIGNATURE OF DECEASED <i>John A. Smith</i>	
97. SIGNATURE OF DECEASED <i>John A. Smith</i>		98. SIGNATURE OF DECEASED <i>John A. Smith</i>		99. SIGNATURE OF DECEASED <i>John A. Smith</i>	
100. SIGNATURE OF DECEASED <i>John A. Smith</i>		101. SIGNATURE OF DECEASED <i>John A. Smith</i>		102. SIGNATURE OF DECEASED <i>John A. Smith</i>	

BUREAU V. S.

JAN 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12700

Reg. Dist. No. 218

12720 FilmG208 12-17-56 et

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 49 W. Diamond Ave		d. STREET ADDRESS 49 W. Diamond Ave.	
3. NAME OF DECEASED (Type or print) First William Middle P. Last Slaughter		4. DATE OF DEATH Month 12 Day 3 Year 1956	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1911
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months 0 Days 9	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Petty Officer		10b. KIND OF BUSINESS OR INDUSTRY Naval Hosp, Bethesda	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Russell P. Slaughter		14. MOTHER'S MAIDEN NAME (First name unknown) Cornwall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 244-60-7942	
17. INFORMANT M.C. Police		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thoracic Hemorrhage 976 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bullet wound thru left chest (heart) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted bullet wound (25 cal. automatic)	
20c. TIME OF INJURY Month, Day, Year Hour XX p. m. 12/3/56	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) (County) (State) Gaithersburg, Montg. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-6-56	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR 12/3/56	
ADDRESS Bethesda, Md.		24b. REGISTRAR'S SIGNATURE Abdula L. Cooke	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12701

Reg. Dist. No.

12721

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>XXXXXX</u> 3 MO. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12518 Epping Ct</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>12578 Epping Ct</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LORRAINE</u> Middle <u>ANNE</u> Last <u>SMALL</u>			4. DATE OF DEATH Month <u>DEC</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <u>9-18-52</u>		9. AGE (In years last birthday) yrs. <u>3</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u>		
11. BIRTHPLACE (State or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Neal Small</u>			14. MOTHER'S MAIDEN NAME <u>Jeannette T. Richard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>father - same as item 2</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 475X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Upper Respiratory Infection</u> (c) <u>Asphyxia</u> (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)		(County)		(State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.						
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>12-20-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/22/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		
22d. LOCATION (City, town, or county) <u>MONTGOMERY COUNTY, MARYLAND</u>		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>			ADDRESS <u>Silver Spring, Md.</u>			
24a. REC'D BY REGISTRAR <u>12/22/56</u>		24b. REGISTRAR'S SIGNATURE <u>Chances</u>				

9VVVVVVVVVV

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 27 1956

RECEIVED

ILLINOIS STATE DEPARTMENT OF HEALTH—BELLINGRUE 18

RECEIVED
DEC 31 1956
LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12703

12723

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		d. STREET ADDRESS 2323 Rose Hill Drive	
3. NAME OF DECEASED (Type or print) First Charles Middle William Last Smith		4. DATE OF DEATH Month December Day 31 , Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 18, 1952
9. AGE (In years lost birthday) 4 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (Infant Child)		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Wilbur Smith		14. MOTHER'S MAIDEN NAME Kathryn Barker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Septicemia - pseudomonas DUE TO (c) acute lymphatic leukemia		INTERVAL BETWEEN ONSET AND DEATH 20 hrs 4 days 3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 25, 1956 , to December 31, 1956 , that I last saw the deceased alive on December 31, 1956 , and that death occurred at 6:55A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Peter B. H'Doubler M.D.		ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 12/31/56	
PHYSICIAN'S NAME (Type) PETER B. H'DOUBLER, M. D.		National Institutes of Health Bethesda 14, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 4, 1957	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Va.
23. FUNERAL DIRECTOR'S SIGNATURE C. P. Jones (prose)		ADDRESS 2847 Wilson Blvd Arlington, Va.	24a. REC'D BY REGISTRAR DATE 2-57
		24b. REGISTRAR'S SIGNATURE Bessie M. Hornsby	

0750 00

The Clinical Center, Bethesda, Md.

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12704

12632

CERTIFICATE OF DEATH

Reg. Dist. No.

213

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>3 wks.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>706 Douglas Ave.</u>		d. STREET ADDRESS <u>706 Douglas Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>INA</u> First <u>RAY</u> Middle <u>SNOWDEN</u> Last		4. DATE OF DEATH <u>Dec. 15</u> Month <u>15</u> Day <u>19</u> Year <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25 1956</u> 9. AGE (In years last birthday) <u>3 wks.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash., D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES F. SNOWDEN</u>		14. MOTHER'S MAIDEN NAME <u>Marion E. Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Mother - Marion Snowden</u> Address <u>706 Douglas Ave. Rockville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> <u>764.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aspiration of Gastric contents</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-15</u> , 19 <u>56</u> , to _____, 19____, that I last saw the deceased alive on <u>NEVER</u> , 19____, and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clive E. Jackson, M.D.</u>		ADDRESS (Street, city or town, state) <u>RD 1, Gaithersburg, Md.</u> DATE SIGNED <u>12-15-56</u>	
PHYSICIAN'S NAME (Type) <u>Clive E. Jackson, M.D.</u>		<u>R. D. 1, Gaithersburg, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>12/17/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial,</u>		22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 18 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Lawell H. Hargrove</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>James F. Snowden</i>		DATE OF DEATH <i>Dec 15 1956</i>	
AGE <i>72</i>		SEX <i>M</i>	
RACE <i>W</i>		EDUCATION <i>High School</i>	
OCCUPATION <i>Retired</i>		PLACE OF BIRTH <i>W.D. Jones, Md.</i>	
RESIDENCE <i>1000 N. ...</i>		DATE OF BIRTH <i>Dec 15 1884</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>James F. Snowden</i>		SIGNATURE OF DECEASED <i>James F. Snowden</i>	
SIGNATURE OF WITNESS <i>James F. Snowden</i>		SIGNATURE OF WITNESS <i>James F. Snowden</i>	

BUREAU V. S.

DEC 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12724

CERTIFICATE OF DEATH

12705
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 3420 13th St., S.E.			
3. NAME OF DECEASED (Type or print) First George Middle (nmn) Last SOTIRELIS				4. DATE OF DEATH Month December Day 14 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 13 Nov. 1927	
9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months 29 Days 29 Hours 29 Min.		IF UNDER 24 HRS. Months 29 Days 29 Hours 29 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME George Sotirelis				14. MOTHER'S MAIDEN NAME Pauline (Last Name Unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> 7-9-45 to 12-14-56				16. SOCIAL SECURITY NO. 067 22 5725		17. INFORMANT (Wife) Kathleen Sotirelis (Same As #2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edema, obstructive of glottis DUE TO (b) Infection of Pharynx, organism not yet determined DUE TO (c) 5 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 13 Dec. 1956 to 14 Dec. 1956 , that I last saw the deceased alive on 14 Dec. 1956 , and that death occurred at 11:20 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Harold I. Passes				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 12-15-56			
PHYSICIAN'S NAME (Type) Harold I. Passes, LT, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-19-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumpfrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 12-15-56	
24b. REGISTRAR'S SIGNATURE Mary E. Parrelly							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

RECEIVED
DEC 19 1956
BUREAU V. S.

12725

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10,204 COLESVILLE ROAD		d. STREET ADDRESS 10,204 COLESVILLE ROAD	
3. NAME OF DECEASED (Type or print) First GEORGE Middle IZLAR Last SOUTHERN		4. DATE OF DEATH Month DECEMBER Day 15 Year 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 1, 1918
9. AGE (In years last birthday) 38 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY FRANK S. BOWEN, INC. WINSTON SALEM, N. C.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE MINER		14. MOTHER'S MAIDEN NAME ANNIE E. BETHEIMER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW #2		16. SOCIAL SECURITY NO. 577-01-3467	
17. INFORMANT Mrs. Margaret G. Southern, 10,204 Colesville Rd., Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the tonsil with metastases 145X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 15, 1956 , to December 15, 1956 , that I last saw the deceased alive on December 15, 1956 , and that death occurred at 11:02 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Bennet A. Porter, Jr. M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 9301 Colesville Rd., Silver Spring, MD, Dec. 15, 56	
PHYSICIAN'S NAME (Type) BENNET A. PORTER, JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/18/56	
22c. NAME OF CEMETERY OR CREMATORY GEO. WASH. MEM. CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner B. Humphrey		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE 12/20/56		24b. REGISTRAR'S SIGNATURE Frances Potter	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 23 1956

RECEIVED

12726

CERTIFICATE OF DEATH

12707

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7707 Tomlinson Ave.</u>		d. STREET ADDRESS <u>7707-TOMLINSON AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE WALTER SPATES</u>		4. DATE OF DEATH Month Day Year <u>DEC- 29 1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 3 1908</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W.C. Transit</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward Spates</u>		14. MOTHER'S MARDEN NAME <u>Ella Shamlon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>WIFE - MARY AGATHA SPATES (SAME AS 1.)</u>	
17. INFORMANT Address <u>WIFE - MARY AGATHA SPATES (SAME AS 1.)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary heart disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/19, 1956</u> , to <u>12/29, 1956</u> , that I last saw the deceased alive on <u>12/29, 1956</u> , and that death occurred at <u>4:10 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. W. Nealou Jr.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>1746 K St NW</u>	
PHYSICIAN'S NAME (Type) <u>Wash 6 D G.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JAN. 2, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HILLSBORO CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>HILLSBORO, VA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. Don. DeVol</u>		24a. REC'D BY REGISTRAR <u>2224 WISAVE D</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1-17-57

NAME OF DECEASED <i>JOHN J. JONES</i>		DATE OF DEATH <i>1-17-57</i>	
AGE <i>68</i>		SEX <i>Male</i>	
RACE <i>White</i>		MARRIAGE <i>Married</i>	
CITY OF DEATH <i>Baltimore</i>		COUNTY OF DEATH <i>Baltimore</i>	
STREET ADDRESS <i>1234 N. E. St.</i>		CITY OF DEATH <i>Baltimore</i>	
STATE OF DEATH <i>Maryland</i>		CITY OF DEATH <i>Baltimore</i>	
DATE OF DEATH <i>1-17-57</i>		TIME OF DEATH <i>10:30 AM</i>	
PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>	
OCCUPATION <i>Retired</i>		EDUCATION <i>High School</i>	
RELIGION <i>Catholic</i>		MARITAL STATUS <i>Married</i>	
DATE OF BIRTH <i>1-1-1889</i>		PLACE OF BIRTH <i>Baltimore</i>	
DATE OF DEATH <i>1-17-57</i>		TIME OF DEATH <i>10:30 AM</i>	
PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Coronary Artery Disease</i>	
OCCUPATION <i>Retired</i>		EDUCATION <i>High School</i>	
RELIGION <i>Catholic</i>		MARITAL STATUS <i>Married</i>	
DATE OF BIRTH <i>1-1-1889</i>		PLACE OF BIRTH <i>Baltimore</i>	

BUREAU V. E.

JAN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12727

CERTIFICATE OF DEATH

12708

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D C b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN 1b 11-19-56-12-9-56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON Gardens Sanitarium				d. STREET ADDRESS 2500 Que Street NW			
3. NAME OF DECEASED (Type or print) ALFRED First A Middle STARBIRD Last				4. DATE OF DEATH 12 Month 9 Day 1956 Year			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-15-1875	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US Army Officer Retired				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MAINE	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME WINFIELD SCOTT STARBIRD				14. MOTHER'S MAIDEN NAME Emmeline Roberts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WWI				16. SOCIAL SECURITY NO.			
17. INFORMANT Mrs Ethel D Starbird Address 2500 Que St NW Washington DC							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart Failure (c) Arterio sclerotic heart disease				INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 11/27 , 19 56 to 12/9/56 , that I last saw the deceased alive on 12/9/56 , and that death occurred at 10 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Charles Weber M.D. DATE SIGNED 12/9/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 12/12/56		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem		22d. LOCATION (City, town, or county) (State) Arlington Virginia			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Hawkers Sons ADDRESS 1756 Pa. Ave. NW Wash.				24a. REC'D BY REGISTRAR 12/12/56		24b. REGISTRAR'S SIGNATURE Frances Potter	

CERTIFICATE OF DEATH

Monaghan

Kensington

11-18-1925

Kensington Gardens Sanatorium

Alfred

Starbuck

White

11-18-1925

James

Starbuck

James Robert

202

11/18/25

BUREAU V. S.

DEC 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12728

CERTIFICATE OF DEATH

12709

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. LENGTH OF STAY IN 1b 12 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE	
4. NAME OF DECEASED (Type or print) First ADA Middle LUELLA Last STEVINSON		4. DATE OF DEATH Month DECEMBER Day 15 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 4, 1885
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID WILMONT COCHRAN		14. MOTHER'S MAIDEN NAME MARGARET CATHERINE HILDINGER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Wm. F. Smith, 7505 Belvedere Blvd.		Address Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aneurysm of Cerebral Vessel DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 days 12 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1945 , 1945, to Dec. 15 , 1956, that I last saw the deceased alive on Dec. 14 , 1956, and that death occurred at 6-11 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William B. Wardrop M.D.		ADDRESS (Street, city or town, state) 837 Bonifant St. Silver Spring, MD.	
PHYSICIAN'S NAME (Type) WILLIAM B. WARDROP		DATE SIGNED 12/16/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/18/56	
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner C. Humphrey,		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE 1-9-56		24b. REGISTRAR'S SIGNATURE Bessie M. Thompson	

2801.4

BUREAU V. 3

DEC 25 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12710

Item 18& Film 209 1-4-57 ans

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 516 Beacon Road			d. STREET ADDRESS 516 Beacon Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charles Middle Daniel Last Stieglitz			4. DATE OF DEATH Month December Day 6 Year 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/13/06	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transportation Specialist		10b. KIND OF BUSINESS OR INDUSTRY ISC		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Charles H. Stieglitz		
14. MOTHER'S MAIDEN NAME Mrs. C. D. Stieglitz			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		
16. SOCIAL SECURITY NO. 252-01-6890			17. INFORMANT Mrs. C. D. Stieglitz Address Same as #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Undetermined 795.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) Autopsy and laboratory findings were neg. (c) Found dead on bedroom floor.					INTERVAL BETWEEN ONSET AND DEATH Found dead on bedroom floor.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Found dead on bedroom floor.					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .					
ACTUAL SIGNATURE Frank J. Broschart			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Frank J. Broschart, M. D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 12/10/56		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY
22d. LOCATION (City, town, or county) ARLINGTON, VIRGINIA			22e. (State) ARLINGTON, VIRGINIA		
23. FUNERAL DIRECTOR'S SIGNATURE Walter B. Humphrey			ADDRESS SILVER SPRING, MD.		
24a. REC'D BY REGISTRAR 12/4/56			24b. REGISTRAR'S SIGNATURE Frances Potter		

STATEMENT OF HEALTH-DEATH IS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG209 1-4-57 et

12711

12730

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Ohio b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Conneaut 72X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 236 Liberty Street			
3. NAME OF DECEASED (Type or print) First Robert Middle Earl Last STOOPS				4. DATE OF DEATH Month December Day 27 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Married	8. DATE OF BIRTH 11 Dec. 1878		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)		11. BIRTHPLACE (State or foreign country) Indiana	
13. FATHER'S NAME Thomas Jefferson STOOPS				14. MOTHER'S MAIDEN NAME Lucina Elizabeth WEITZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-1 & II		17. INFORMANT (Wife) Mrs Ethel Louise STOOPS (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 13 Nov. 1956 , to 27 Dec. 1956 , that I last saw the deceased alive on 27 Dec. 1956 , and that death occurred at 1:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED U.S. Naval Hospital, Bethesda, Md. 12-27-56							
ACTUAL SIGNATURE R. J. Mc Carthy				M.D. U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) R. J. MC CARTHY, CDR, MC, USN				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				ADDRESS Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-27-56	
R. A. Pumphrey Funeral Home, 7557 Wisconsin Ave.,				24b. REGISTRAR'S SIGNATURE Mary E. Cassidy			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
JAMES J. HENRY		MALE		45	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JAN 10 1956		BALTIMORE, MD.		HEART DISEASE	
DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAN 10 1911		BALTIMORE, MD.		LABORER	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
JAN 10 1956		BALTIMORE, MD.		HEART DISEASE	
DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
JAN 10 1911		BALTIMORE, MD.		LABORER	

RECEIVED
DEC 28 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12731

CERTIFICATE OF DEATH

12712

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Alexandria			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 107 Yale Ave.,			
3. NAME OF DECEASED (Type or print) Baby First Girl Middle SAFFORD Last				4. DATE OF DEATH Month Dec. Day 3 Year 1956			
5. SEX Female		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 Dec. 1956	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
						1 7	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Judson H. Swafford				14. MOTHER'S MAIDEN NAME Annie Myrtle Swafford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT (Father) Judson H. Swafford (Same As #2)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Erythroblastosis fetalis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 65 minutes							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3 Dec. , 19 56 , to 3 Dec. , 19 56 , that I last saw the deceased alive on 3 Dec. , 19 56 , and that death occurred at 5:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John H. Mazur M.D. U.S. Naval Hospital, Bethesda, Md. 12-4-56							
ACTUAL SIGNATURE John H. Mazur M.D. U.S. Naval Hospital, Bethesda, Md. 12-4-56							
PHYSICIAN'S NAME (Type) John H. Mazur, LT, MC, USN U.S. Naval Hospital, Bethesda, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-6-56		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R.A. Humphrey				ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-4-56	
24b. REGISTRAR'S SIGNATURE Mary E. Parselly							

2051295XV3

CERTIFICATE OF DEATH

Name of Deceased (Print Name)		Date of Birth	
Sex		Race	
Usual Residence		Place of Birth	
Date of Death		Cause of Death	
Date of Burial		Place of Burial	
Name of Physician		Name of Undertaker	
Signature of Physician		Signature of Undertaker	
Date of Issuance		Place of Issuance	

BUREAU V. S.

DEC 7 1956

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12732

CERTIFICATE OF DEATH

Reg. Dist. No.

12713

214

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 6 yrs.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8610 2nd AVENUE				d. STREET ADDRESS 8610 2nd AVENUE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First JESSIE Middle HALLEY Last SWANK				4. DATE OF DEATH Month DEC. Day 5 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 9, 1869		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES HALLEY				14. MOTHER'S MAIDEN NAME HELEN McDOUGAL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address Mrs. Sidney M. Oliver, 8610 2nd Ave. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5-10 yrs 5-10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-24 , 19 51 , to 12-5 , 19 56 , that I last saw the deceased alive on 12-4 , 19 56 , and that death occurred at 2:38 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE N.T. Lucius				ADDRESS (Street, city or town, state) 9321 Georgia Ave. Silver Spring, Md.		DATE SIGNED 12/5/56	
PHYSICIAN'S NAME (Type) N.T. LUCIUS							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/7/56		22c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey ADDRESS SILVER SPRING, MARYLAND				24a. REC'D BY REGISTRAR DATE 12/6/56		24b. REGISTRAR'S SIGNATURE Frances Pitter	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12714

12733

CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>4 1/2</u> years							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>720 Thayer Avenue</u>				d. STREET ADDRESS <u>720 Thayer Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>Stuart</u> Last <u>Tingley</u>				4. DATE OF DEATH Month <u>December</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 28, 1870</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Foster E. Stuart</u>				14. MOTHER'S MAIDEN NAME <u>Abbie M. Locke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT <u>Charles O. Tingley</u>		Address <u>720 Thayer Ave. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11.</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>19 36</u> , to <u>Dec. 23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 21</u> , 19 <u>56</u> , and that death occurred at <u>12:45</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) <u>1635 Harvard St. N. W., Wash. DC</u>			
DATE SIGNED <u>12/23/56</u>							
PHYSICIAN'S NAME (Type) <u>Wyrt Post Baker</u>				<u>1635 Harvard St. N. W., Wash. DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Francis J. Collins 3821-14th St. NW Wash DC</u>				24a. REC'D BY REGISTRAR DATE <u>12/27/56</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
DEC 31 1961
U. S. AIR FORCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG209 1-4-57 et

12734

CERTIFICATE OF DEATH

12715
Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 3 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery County General Hospital, Inc.		d. STREET ADDRESS Rt. #2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Turner Last Turner		4. DATE OF DEATH Month December Day 5 Year 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/27/88 88
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wilbert Pierce		14. MOTHER'S MAIDEN NAME Annie Myers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hospital Record (Son)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno carcinoma cervix 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Cholelithiasis DUE TO (c) Shock following Exploratory Operation PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 2 18 hrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/11 , 19 56 , to 12/5 , 19 56 , that I last saw the deceased alive on 12/4/56 , 19 56 , and that death occurred at 2:42 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE J. W. Bird, M. D. M.D. Sandy Spring 12/5/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 5/56	
22c. NAME OF CEMETERY OR CREMATORY Union Burial Home		22d. LOCATION (City, town, or county) (State) Montgomery Co MD	
23. FUNERAL DIRECTOR'S SIGNATURE Roy W Barber		24a. REC'D BY REGISTRAR 12/7/56	
24b. REGISTRAR'S SIGNATURE Gertrude B. Law			

715

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
12622 CERTIFICATE OF DEATH										
Reg. Dist. No. 12716 223										
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park					c. LENGTH OF STAY IN 1b 18 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Margaret Middle Cecelia Last Veitch					4. DATE OF DEATH Month December Day 11 Year 1956					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-24-97		9. AGE (In years last birthday) 59 yrs. IF UNDER 1 YEAR: Months 11 Days 11 Hours 19 Min. 56		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary			10b. KIND OF BUSINESS OR INDUSTRY Capital Nurses Reg.			11. BIRTHPLACE (State or foreign country) D. C.			12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME James J. Mc Intyre					14. MOTHER'S MAIDEN NAME Mary Ulrich					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----					17. INFORMANT Hospital Records Address -----					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstructive jaundice DUE TO Obstruction of common duct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Carcinoma of Gall Bladder DUE TO ----- (b) ----- (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) -----										
INTERVAL BETWEEN ONSET AND DEATH 3 wks										
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Nov. 12 , 19 56 , to Dec. 11 , 19 56 , that I last saw the deceased alive on Dec. 11 , 19 56 , and that death occurred at 7:25 P.M. , from the causes and on the date stated above.										
ACTUAL SIGNATURE Philip C. Jones M.D.					ADDRESS (Street, city or town, state) 918 Chelworth Drive Silver Spring, Md DATE SIGNED 12-12-56					
PHYSICIAN'S NAME (Type) -----										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF Dec. 14, 1956		22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens			22d. LOCATION (City, town, or county) (State) Washington, D. C.		
23. FUNERAL DIRECTOR'S SIGNATURE C. P. Lee ADDRESS Washington, D. C.					24a. REC'D BY REGISTRAR 12/13/56 24b. REGISTRAR'S SIGNATURE -----					

BUREAU V. S.

DEC 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12735

CERTIFICATE OF DEATH

12717

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.				c. LENGTH OF STAY IN 1b 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Honeybrook			
				d. STREET ADDRESS Route # 2			
3. NAME OF DECEASED (Type or print) First Charles Middle C. Last Warfel				4. DATE OF DEATH Month December Day 15 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1870	9. AGE (In years lost birthday) yrs. 86	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker				10b. KIND OF BUSINESS OR INDUSTRY Bakery		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME A. W. Warfel				14. MOTHER'S MAIDEN NAME Christiana Snavelly			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 205-05-8460		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 141X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Tongue, pharynx & epiglottis (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 9 p. m. Month, Day, Year 19 56				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from November 19, 19 56 to December 15, 19 56 , that I last saw the deceased alive on December 15, 19 56 , and that death occurred at 3:58 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Gurston Goldin, M.D.				ADDRESS (Street, city or town, state) The Clinical Center			
PHYSICIAN'S NAME (Type) GURSTON GOLDIN				DATE SIGNED 12/18/56			
22b. DATE THEREOF 12/20/56				22c. NAME OF CEMETERY OR CREMATORY Mt. Zion			
22d. LOCATION (City, town, or county) Lancaster, Pa.				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.				24a. REC'D BY REGISTRAR 12-18-56			
				24b. REGISTRAR'S SIGNATURE Bernie M. Thompson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		White		1911		Maryland		Natural		Heart Disease		1956		Baltimore		J. A. Smith		M. J. Jones	

BUREAU V. R.

DEC 21 1956

RECEIVED

Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		White		1911		Maryland		Natural		Heart Disease		1956		Baltimore		J. A. Smith		M. J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12718

12736

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY —	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.		d. STREET ADDRESS 5338 Wright Ave.,	
3. NAME OF DECEASED (Type or print) First Raymond Middle Gaylen Last WEBSTER		4. DATE OF DEATH Month December Day 20 Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 May 1898
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy (Retired)	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Webster (Deceased)		14. MOTHER'S MAIDEN NAME Mary Pennington (Deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW-I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Wife) Mrs. Harriet Webster (Same As #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II (a)		INTERVAL BETWEEN ONSET AND DEATH 5 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 23 Oct. , 19 56 , to 20 Dec. , 19 56 , that I last saw the deceased alive on 20 Dec. , 19 56 , and that death occurred at 08:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE J. T. Horgan		M.D. U.S. Naval Hospital, Bethesda, Md. 12-20-56	
PHYSICIAN'S NAME (Type) J. T. HORGAN, LT, MC, USN		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-22-56	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Frieda J. Miller, 2435 E. Oliver, Baltimore, Md.		24a. REC'D BY REGISTRAR DATE 12-20-56	
24b. REGISTRAR'S SIGNATURE Mary E. Parrelly			

DEC 26 1956

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12737

CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1203 Ballard Street				d. STREET ADDRESS 1203 Ballard Street			
3. NAME OF DECEASED (Type or print) MAUDE MAY WHITE				4. DATE OF DEATH Dec. 28, 19 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1888	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 7 Days 19	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Hull				14. MOTHER'S MAIDEN NAME Sarah M. Roberts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Laurence W. White-Item # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liposarcoma, retroperitoneal, & metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 197X DUE TO (c) 2 1/2 mos							INTERVAL BETWEEN ONSET AND DEATH 2 1/2 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September, 1956 , to December 28, 1956 , that I last saw the deceased alive on December 27, 1956 , and that death occurred at 10:10 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Bennet A. Porter, Jr., M.D.				ADDRESS (Street, city or town, state) 9301 Colesville Rd., Silver Spring, Md.		DATE SIGNED Dec. 28, 1956	
PHYSICIAN'S NAME (Type) Bennet A. Porter, Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31/56		22c. NAME OF CEMETERY OR CREMATORY George Washington Mem. Prince George Co., Maryland		22d. LOCATION (City, town, or county) (State) 	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Maryland				24a. REC'D BY REGISTRAR 12/31/56		24b. REGISTRAR'S SIGNATURE James Potter	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 31 1956
BUREAU V. S.

RECEIVED
DEC 31 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

14
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12720

12623

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7325 BALTIMORE AVE.</u>		d. STREET ADDRESS <u>7325 BALTIMORE AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>F.</u> Last <u>WILCOX</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 13, 1870</u>
9. AGE (In years lost birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUILDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING</u>	11. BIRTHPLACE (State or foreign country) <u>OHIO</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>NOT AVAILABLE</u>	
14. MOTHER'S MAIDEN NAME <u>NOT AVAILABLE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>280 22 516</u>		17. INFORMANT <u>FAIRL D. C.E. REICHENBAUGH</u> Address <u>(SAME AS ABOVE)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Complete heart block (several months)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>56</u> , to <u>Dec 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 5</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John N. Andre</u> M.D.		ADDRESS (Street, city or town, state) <u>9601 Colesville Rd</u> DATE SIGNED <u>Dec 6-56</u>	
PHYSICIAN'S NAME (Type) <u>John N. Andre, M.D.</u>		<u>Silver Spring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANSIT-BURIAL</u>		22b. DATE THEREOF <u>DEC 8, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>NEW CANTON OHIO</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u> ADDRESS <u>234 CARROLL ST. NW. DC</u>		24a. REC'D BY REGISTRAR DATE <u>12/8/56</u>	
24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dobb</u>			

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. PLACE OF BIRTH	
3. SEX		4. AGE	
5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH	
9. NAME OF DECEASED		10. NAME OF NEXT OF KIN	
11. NAME OF PHYSICIAN		12. NAME OF BURIAL PLACE	
13. NAME OF MINISTER		14. NAME OF FUNERAL HOME	
15. NAME OF CEMETERY		16. NAME OF INTERMENT	
17. NAME OF INTERMENT		18. NAME OF INTERMENT	
19. NAME OF INTERMENT		20. NAME OF INTERMENT	
21. NAME OF INTERMENT		22. NAME OF INTERMENT	
23. NAME OF INTERMENT		24. NAME OF INTERMENT	
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29. NAME OF INTERMENT		30. NAME OF INTERMENT	
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91. NAME OF INTERMENT		92. NAME OF INTERMENT	
93. NAME OF INTERMENT		94. NAME OF INTERMENT	
95. NAME OF INTERMENT		96. NAME OF INTERMENT	
97. NAME OF INTERMENT		98. NAME OF INTERMENT	
99. NAME OF INTERMENT		100. NAME OF INTERMENT	

BUREAU V. 2

DEC 10 1956

RECEIVED

12738

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 5½ hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 5322 Yroktown Blvd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Walter Middle Wallace Last WILDE				4. DATE OF DEATH Month December Day 23 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-1890	9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inn Keeper		10b. KIND OF BUSINESS OR INDUSTRY Commercial		11. BIRTHPLACE (State or foreign country) Rhode Island		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John A. Wilde				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown		17. INFORMANT Address (Son) Ronald B. Wilde, (Same As #2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Cerebrovascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Hypertensive arteriosclerotic cardiovascular disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5½ hour	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 23 Dec. 19 56 to 23 Dec. 19 56 , that I last saw the deceased alive on 23 December 19 56 , and that death occurred at 10:35 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Russell Miller, Jr.		ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md.					
PHYSICIAN'S NAME (Type) Russell Miller, Jr. LT, MC, USN		DATE SIGNED 12-23-56					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-27-56		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery		22d. LOCATION (City, town, or county) (State) North Attleboro, Mass.	
23. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		ADDRESS 7557 Wisconsin Ave., Bethesda, Md.		24a. REC'D BY REGISTRAR 12-23-56		24b. REGISTRAR'S SIGNATURE Harry E. Russell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased JAMES H. HARRIS		Sex Male		Age 35 years	
Date of Death December 26, 1956		Place of Death Home		Cause of Death Heart Disease	
Occupation Unknown		Usual Residence 1234 Main St., New York, N.Y.		Manner of Death Natural	
Date of Birth 1921		Place of Birth New York, N.Y.		Race White	
Married Yes		Spouse's Name Mary Harris		Date of Marriage 1945	
Last Seen Alive December 25, 1956		Found Dead Yes		Time of Death 10:00 AM	
Physician's Name Dr. J. K. Smith		Hospital Name St. Mary's Hospital		City New York	
County New York		State New York		Country U.S.	
Signature of Physician J. K. Smith		Signature of Registrar J. K. Smith		Signature of Informant J. K. Smith	

BUREAU V. S.

DEC. 26 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12739

CERTIFICATE OF DEATH

12722

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY: Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE: New Jersey b. COUNTY: Chatham			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 14, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chatham			
c. LENGTH OF STAY IN 1b 139 days				d. STREET ADDRESS 5 Overlook Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Tschudy Last Williams			4. DATE OF DEATH Month December Day 9 Year 1956				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH November 29, 1902		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months 54 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Tschudy				14. MOTHER'S MAIDEN NAME Annie Brunner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 152-28-5735		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic lymphocytic leukemia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 11 Month 19 Day 19 Year 1956 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bethesda 14, Maryland		(County) (State)	
21. I certify that I attended the deceased from July 23 , 1956, to December 9 , 1956, that I last saw the deceased alive on December 9 , 1956, and that death occurred at 1:05 p.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Weissman M.D.				ADDRESS (Street, city or town, state) The Clinical Center		DATE SIGNED 12/9/56	
PHYSICIAN'S NAME (Type) S. WEISSMAN, M. D.				National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-13-56	22c. NAME OF CEMETERY OR CREMATORY Lose Land Mem. Park		22d. LOCATION (City, town, or county) (State) East Hanover, New Jersey			
23. FUNERAL DIRECTOR'S SIGNATURE Howard E. Hubbard, 4107 Wilkens Ave				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Beaue Thompson	

DEC 14 1956

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12723

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b Since May '56		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1219 NOYES DRIVE			d. STREET ADDRESS 1219 NOYES DRIVE		
3. NAME OF DECEASED (Type or print) First RAYMOND CARL WILLIAMS Middle Last			4. DATE OF DEATH Month DECEMBER Day 14 Year 19 56		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 16, 1907	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President, Capital City		10b. KIND OF BUSINESS OR INDUSTRY Savings & Loan Ass'n.		11. BIRTHPLACE (State or foreign country) Washington, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Clyde Downs Williams			
14. MOTHER'S MAIDEN NAME Grace O. Delabar		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. YES		17. INFORMANT Address Mrs. Madeline S. Williams, 1219 Noyes Drive Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hour					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT	22b. DATE THEREOF 12/17/56	22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY	22d. LOCATION (City, town, or county) (State) PRINCE GEORGE COUNTY, MD.		
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Humphrey		ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR 12/17/56	24b. REGISTRAR'S SIGNATURE Frances Collier

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
DEC 20 1956
BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12741

CERTIFICATE OF DEATH

Reg. Dist. No.

12724

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>3521 39th St, N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Kyle Darby Winkler</u>		4. DATE OF DEATH <u>December 13 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 12/56</u>
9. AGE (In years lost birthday) yrs. <u>6</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>6 48</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Bethesda, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bartlett Compton Winkler</u>		14. MOTHER'S MAIDEN NAME <u>Suzanne Hawkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mother</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PRE MATURITY</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours 48 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Dec 12, 1956</u> , to <u>Dec 13, 1956</u> , that I last saw the deceased alive on <u>Dec 13, 1956</u> , and that death occurred at <u>1:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank Jagers</u>		M.D. <u>5707 Wisconsin Ave</u>	
PHYSICIAN'S NAME (Type) <u>Frank Jagers</u>		DATE SIGNED <u>12/13/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12-14-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) <u>Prince Georges</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda Md</u>	
24a. REC'D BY REGISTRAR <u>12-14-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bev M Thompson</u>	

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CERTIFICATE OF DEATH

Page No. 1

BUREAU V. S.

DEC 17 1956

RECEIVED

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12742

CERTIFICATE OF DEATH

12725
217

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 3 YRS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 9325 OCALA STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 708 PHILADELPHIA AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERTA Middle YATES Last WITHERS		4. DATE OF DEATH Month DEC. Day 23 Year 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 8, 1878
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FILE CLERK - Federal Bureau of Investigation		10b. KIND OF BUSINESS OR INDUSTRY VIRGINIA	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY CLAY YATES		14. MOTHER'S MAIDEN NAME ELIZABETH DESHIELDS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Claude B. Clagett, 9325 Ocala St. Silver Spring, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 4343 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage (Nov-1951)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/16 , to 23 Dec , 19 56 , that I last saw the deceased alive on 15 Oct , 19 56 , and that death occurred at 3 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Aud M.D.		ADDRESS (Street, city or town, state) 9106 Cokesville Rd Silver Spring Md	
PHYSICIAN'S NAME (Type) WILLIAM D. AUD		DATE SIGNED 12/24/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/26/56	
22c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE 12/27/56	
		24b. REGISTRAR'S SIGNATURE James Potter	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

RECEIVED
DEC 31 1956

12743

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Georgia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 14 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Madison				49x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center				d. STREET ADDRESS 101 East Central Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First James Middle Lincoln Last Withrow				4. DATE OF DEATH Month December Day 16 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 July 1911		9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroader		10b. KIND OF BUSINESS OR INDUSTRY Transportation		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oscar J. Withrow				14. MOTHER'S MAIDEN NAME Ann Wittington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT The Medical Record, Clinical Center			
(If yes, give war or dates of service)				National Institutes of Health, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Rheumatic Carditis (c) Congestive Heart Failure							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial + Aortic Stenosis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 1 p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2 December, 1956 , to 16 December, 1956 , that I last saw the deceased alive on 16 December, 1956 , and that death occurred at 10:25 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Duncan L. McCollester, M.D.				ADDRESS (Street, city or town, state) The Clinical Center			
PHYSICIAN'S NAME (Type) Duncan L. McCollester, Md.				DATE SIGNED 12/17/56			
NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Tr.		22b. DATE THEREOF 12-18-56		22c. NAME OF CEMETERY OR CREMATORY City Cemetery		22d. LOCATION (City, town, or county) (State) Madison, Morgan Co Ga	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Md		24a. REC'D BY REGISTRAR 12-18-56	
				24b. REGISTRAR'S SIGNATURE Beau M. Romberger			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEC 21 1956

RECEIVED

12741
CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <u>MONTG.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LEDEAU GARDENS NURSING HOME</u>		d. STREET ADDRESS <u>10504 S DUNMOOR RD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE ROBERTA WOLFREY</u>		4. DATE OF DEATH Month Day Year <u>DEC 28 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 17 1874</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>STAUNTON VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID SHEARER</u>		14. MOTHER'S MAIDEN NAME <u>HANNIE SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address <u>Records at Nursing Home, Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE HEART FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>AORTIC ANEURISM</u> DUE TO (c) <u>ARTERIO SCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>SEPT</u> , 19 <u>58</u> , to <u>DEC 27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>DEC 27</u> , 19 <u>58</u> , and that death occurred at <u>1:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert T. Thibadeau, M.D.</u>		ADDRESS (Street, city or town, state) <u>10609 CONCORD ST, KENSINGTON, MD</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>		DATE SIGNED <u>12/31/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12/29/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co</u>		ADDRESS <u>2901-14th St NW</u>	
24a. REC'D BY REGISTRAR <u>12/31/58</u>		24b. REGISTRAR'S SIGNATURE <u>Francis Potter</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		M		35		W		1922		MEMPHIS, TENN.		APR 4 1968		MEMPHIS, TENN.		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. MARITAL STATUS		15. EDUCATION		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
ATTORNEY		MARRIED		HIGH SCHOOL		METHODIST		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

1957

RECEIVED

12624

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7100 Sycamore Ave Nursing Home</u>		d. STREET ADDRESS <u>4604 Rosedale Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Herbert Alphons Wrenn</u>		4. DATE OF DEATH <u>Dec 31 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 12 1879</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles A. Wrenn</u>		14. MOTHER'S MAIDEN NAME <u>Martha A. Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Wm Lucas - 4604 Rosedale Ave, Bethesda, Md</u>	
17. INFORMANT <u>Wm Lucas - 4604 Rosedale Ave, Bethesda, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Gen Arteriosclerosis & Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1953</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>34 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr Cystitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>12</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City and town) (County) (State)	
21. I certify that I attended the deceased from <u>1/13/1955</u> , to <u>12/31/1956</u> that I last saw the deceased alive on <u>12/30/1956</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. T. Morse</u> M.D.		ADDRESS (Street, city or town, state) <u>2030 Carroll Ave</u> DATE SIGNED <u>12/31/56</u>	
PHYSICIAN'S NAME (Type) <u>H. T. Morse</u>		<u>Takoma Park Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>1/3/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ch. H. Jones Co., Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>Jan 2 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Alphon Dezel</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12729

12745

CERTIFICATE OF DEATH

Reg. Dist. No.

2116

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>7110 - 44th STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lillian Summers WRENN</u>				4. DATE OF DEATH Month Day Year <u>12 - 10 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-6-86</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Charlottesville, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>White S. Stotts</u>				14. MOTHER'S MAIDEN NAME <u>Lillie Bailes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Wm. Russell (daughter)</u>				Address <u>7110 - 44th ST. CC, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute monocytic leukemia</u> <u>204.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12 Oct</u> , 19 <u>56</u> , to <u>10 Dec</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10 Oct</u> , 19 <u>56</u> , and that death occurred at <u>2:00 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Herbert Martyn Jr</u> M.D. <u>5029 Bethesda Ave.</u> <u>10 Oct 56</u>				ADDRESS (Street, city or town, state) <u>Beth. Md</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>HERBERT MARTYN JR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		22b. DATE THEREOF <u>12/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR <u>12-11-56</u> 24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

REG. FILE NO.

NAME OF DECEASED <i>John Doe</i>		SEX <i>Male</i>		AGE <i>45</i>	
DATE OF DEATH <i>Dec 10 1956</i>		PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>	
DATE OF BIRTH <i>Jan 15 1911</i>		PLACE OF BIRTH <i>Baltimore</i>		OCCUPATION <i>Teacher</i>	
MANNER OF DEATH <i>Natural</i>		EDUCATION <i>High School</i>		RELIGION <i>Catholic</i>	
MARITAL STATUS <i>Married</i>		PREVIOUS ILLNESS <i>None</i>		HISTORY OF DRUGS <i>None</i>	
SIGNED BY <i>Dr. Smith</i>		DATE <i>Dec 10 1956</i>		PLACE <i>Baltimore</i>	
FAMILY PHYSICIAN <i>Dr. Smith</i>		HOSPITAL <i>None</i>		LABORATORY <i>None</i>	
CORONER <i>None</i>		BURIAL <i>None</i>		OTHER <i>None</i>	

BUREAU V. R.

DEC 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12746

CERTIFICATE OF DEATH

Reg. Dist. No. 214

12730

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>524 Western Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Cordelia</u> Middle <u>D.</u> Last <u>Wright</u>				4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-22-19</u>	9. AGE (In years lost birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>24</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Calvin G. Bennett</u>				14. MOTHER'S MAIDEN NAME <u>Mrs Annie Bruce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-46-8935B</u>		17. INFORMANT <u>Mrs E.A. Zimmerman</u>		Address <u>1654 Pinrose Rd N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adeno. carcinoma left breast</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u> <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 5</u> , 19 <u>56</u> , to <u>Dec 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 15</u> , 19 <u>56</u> , and that death occurred at <u>3:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Sidney C. Cousins</u> M.D. <u>3927 INGRAM ST NW</u>				DATE <u>12/16/56</u>			
PHYSICIAN'S NAME (Type) <u>SIDNEY C. COUSINS</u>				<u>WASH. DC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/18/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>12-18-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is partially obscured by a large, dark, irregular stain in the center.

BUREAU V. 81

DEC 21 1956

RECEIVED

10/10/56
J. J. [illegible]
[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12731
214

12747 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2503 KIMBERLY ST.</u>				d. STREET ADDRESS <u>2503 KIMBERLY ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>ELLEN</u> Last <u>WRIGHT</u>				4. DATE OF DEATH Month <u>DEC.</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 3, 1863</u>	9. AGE (In years last birthday) <u>93</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>FROSTBURG, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>							
13. FATHER'S NAME <u>CORNELIUS DAILEY</u>				14. MOTHER'S MAIDEN NAME <u>MARY McCARTNEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>THOMAS P. WRIGHT, 2503 KIMBERLY ST. SILVER SPRING, Md.</u>			
17. INFORMANT Address <u>SILVER SPRING, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO 25 years (c) <u>13 days</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 1, 1956</u> , to <u>Dec. 28, 1956</u> , that I last saw the deceased alive on <u>Dec. 28, 1956</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>John J. Curry</u> M.D. <u>10620 Gemini Ave. 12/28/56</u>							
PHYSICIAN'S NAME (Type) <u>JOHN J. CURRY</u>				<u>Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 31, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PATRICK'S CHURCH CEMETERY CUMBERLAND, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Staller</u> ADDRESS <u>254 CARROLL ST. N.W.</u>				24a. REC'D BY REGISTRAR <u>JAN 2 1957</u>		24b. REGISTRAR'S SIGNATURE <u>James P. Kelly</u>	

CERTIFICATE OF DEATH

REG. DIST. NO.

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. SIGNATURE OF PHYSICIAN</p>	
<p>11. SIGNATURE OF REGISTRAR</p>		<p>12. DATE</p>	

BUREAU V. S.

JAN 2 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12732

12748

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 76 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 5815 Sherrier Place, NW,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Walter Middle Joseph Last YEBENS		4. DATE OF DEATH Month DEC Day 1 Year 19 56			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 18 1894	
9. AGE (In years last birthday) 62 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Worker		10b. KIND OF BUSINESS OR INDUSTRY District Government		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Cirk YEBENS				14. MOTHER'S MAIDEN NAME Alice RAYNOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		(If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Wife) Irene D. YEBENS, 5815 Sherrier Place, NW, Wash, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic failure 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) metastatic carcinoma DUE TO (c) CARCINOMA, stomach						INTERVAL BETWEEN ONSET AND DEATH weeks undetermined "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 17 , 19 56 , to Dec. 1 , 19 56 , that I last saw the deceased alive on 1 December , 19 56 , and that death occurred at 1:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Wm B Ingram				ADDRESS (Street, city or town, state) U.S. Naval Hospital, Bethesda, Md. DATE SIGNED 12-3-56			
PHYSICIAN'S NAME (Type) Wm. B. Ingram, CDR, MC, USN				U.S. Naval Hospital, Bethesda, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-5-56		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Chambers Funeral Home ADDRESS Chambers Funeral Home, 3072 "M" St. Wash. D.C.				24a. REC'D BY REGISTRAR DATE 12-2-56		24b. REGISTRAR'S SIGNATURE Mary E. Russell	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12733

12749

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 5112 Second Street, N.W.	
3. NAME OF DECEASED (Type or print) First Rose Middle Julia Last Zachrel		4. DATE OF DEATH Month December Day 10 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 January 1933
9. AGE (In years lost birthday) 23 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Pokomo		14. MOTHER'S MAIDEN NAME Mary Biabik	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT The Medical Record, The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) POST OPERATIVE APNSA c TERMINAL VENTRICULAR FIBRILLATION 410 X DUE TO SURGERY FOR RELIEF OF MITRAL INSUFFICIENCY Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. } DUE TO RHEUMATIC HEART DISEASE c MITRAL INSUFFICIENCY 12 YRS. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. g. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 November, 1956 , to 10 December, 1956 , that I last saw the deceased alive on 10 December, 1956 , and that death occurred at 4:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center, National Institutes of Health, Bethesda 14, Maryland DATE SIGNED Theodore Cooper, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 12/11/56		22b. DATE THEREOF 12/11/56	
22c. NAME OF CEMETERY OR CREMATORY Monesson		22d. LOCATION (City, town, or county) (State) Monesson, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md.		24a. REC'D BY REGISTRAR DATE 12-11-56	
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson			

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
The Star and Center, Baltimore, Md.		Male		35		Jan 1, 1925		Baltimore, Md.		Baltimore		Maryland		United States of America	
RACE		COLOR		RELIGION		EDUCATION		OCCUPATION		MARITAL STATUS		PREVIOUS ILLNESS		CAUSE OF DEATH	
Caucasian		White		Roman Catholic		High School		Clerk		Married		Tuberculosis		Tuberculosis of the lungs	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
Jan 15, 1956		Baltimore, Md.		Baltimore		Maryland		United States of America		Jan 15, 1956		Baltimore, Md.		Baltimore	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

DEC 13 1956

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